Date:_____

MEDICAL HISTORY UPDATE

Patient Name _____

Address: (if changed):_____

Phone #: _____ Work Phone#:_____

Person to contact in an emergency: _____Phone#:_____

Insurance (if changed): _____

Personal Physician's Name:_____

Address:_____

Phone #:_____

The approximate date of your last doctors visit_____

Your current physical health is:

❑ Good ❑ Fair ❑ Poor

Are you currently under the care of any physician?

❑ Yes ❑ No

If yes, please explain:_____

_____

Do you smoke or use tobacco in any other form?

❑ Yes ❑ No

Are you presently taking any drugs prescribed by a physician or dentist? ❑ Yes ❑ No

If yes, please list:_____

_____

Are you taking aspirin? ❑ Yes ❑ No

Are you taking blood thinners? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

Have you been told that you need to take antibiotics before any dental procedure(s) ❑ Yes ❑ No

Have you had any serious medical problems in the last 5 years? ❑ Yes ❑ No

If yes , please explain:_____

_____

Have you ever had any of the following diseases or medical problems?

Heart Attack	Y N	HIV+/AIDS	Y N
Heart Murmur/Rheumatic	Y N	Shingles	Y N
Fever or other Cardiac Problems	Y N	Kidney Problems	Y N
		Sinus Problems	Y N
Heart Surgery/Pacemaker	Y N	Fever Blisters/Herpes	Y N
Stroke	Y N	Psychiatric Problems	Y N
Hip & Joint Replacement	Y N	Diabetes	Y N
Chronic Hepatitis	Y N	Tuberculosis (TB)	Y N
Anemia	Y N	Sickle Cell Disease	Y N
High/Low Blood Pressure	Y N	Asthma	Y N
Severe Headaches	Y N	Lung Problems	Y N
Epilepsy/Seizures/Fainting Spells	Y N	Respiratory Issues	Y N
		Sleep Apnea	Y N
Drug/Alcohol Abuse	Y N	Neurological Problems	Y N
Thyroid	Y N	Artificial joints or Valves	Y N
Hemophilia/Abnormal Bleeding	Y N	Antiresorptive Bone	Y N
Cancer/Chemotherapy/Radiation			

Doctor's Comments:_____

_____

_____

Have you experienced any other serious medical conditions that are not listed above? ❑ Yes ❑ No

If yes, please list:_____

_____

_____

Are you allergic to any of the following?

Penicillin	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Metals	Y N
Latex	Y N	Acrylics	Y N
Aspirin	Y N	Opioids like Codeine/Hydrocodone	Y N

Are you allergic to any other drugs? ❑ Yes ❑ No

If yes, please list:_____

_____

_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

AT LEAST 48 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE A CANCELLATION CHARGE OF $75.00 WILL BE MADE.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical statue.

Signature Date