Medical History Update

Patient Name: ________________________________ DOB: _________________

Changes to mailing address: YES □ NO □

Address: ____ Apt.__________

City: _________________________ State: ____________ Zip: ___________

Any changes to contact phone numbers or email? YES □ NO □

Home: (____) ____________________ Cell: (____) ____________________

Email: ____

New or updated insurance? YES □ NO □

If yes, please provide a copy of your new insurance card to the front desk.

Are you currently experiencing any of the conditions listed below?		YES	NO
Arthritis		□	□
Asthma		□	□
Hay fever		□	□
Anemia		□	□
Diabetes		□	□
Blood disorder		□	□
Fainting spells		□	□
Sinus trouble		□	□
Tuberculosis		□	□
Ulcers		□	□
Nervous disorder		□	□
Blood pressure problems	High/Low	□	□
Kidney disease		□	□
Congenital heart disorder or heart murmur		□	□
Hepatitis (A,B,C), jaundice, or liver disease		□	□
HIV Infection/AIDS		□	□
Lung or breathing disorder		□	□
Rheumatic fever, Scarlet fever		□	□
Seizures e.g. epilepsy or stroke		□	□
Do you have a history of substance abuse?		□	□
Are you currently using recreational drugs?		□	□
Do you smoke, or chew tobacco?		□	□

If yes, how much? ____

	YES	NO
Cancer /tumors	□	□

If yes, when, and what type: ____

	YES	NO
Joint Replacement	□	□

If yes, when, and which joint: ____

Are you pregnant? □

If yes, how many weeks? _______________ What is your due date? _______________

Have you had any recent surgical procedures? YES□ NO□

If you answered YES to any of the above medical conditions, please explain any further details regarding said condition:

Are you currently experiencing any conditions/illnesses that are NOT listed above? If yes list them below:

List any medications you are currently taking:

Allergies

□ None □ Penicillin □ Asprin □ Nsaids □ Local Anesthetics □ Acrylic □Latex

□ Sulfa □ Codeine □ Metal □ Seasonal □ Other