## PATIENT INFORMATION UPDATED FORM

<table>
<thead>
<tr>
<th>Date:</th>
<th>☐ UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient:</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

### LAST  FIRST  MI  PREFERRED  TITLE

- ☐ MALE  ☐ FEMALE  ☐ CHILD*  ☐ STUDENT**  ☐ SINGLE  ☐ MARRIED  ☐ DIVORCED  ☐ WIDOWED

## MEDICAL HISTORY UPDATES

### GENERAL HEALTH: ☐ EXCELLENT  ☐ GOOD  ☐ FAIR  ☐ POOR

- ☐ Y ☐ N  Under a physician’s care now?
- ☐ Y ☐ N  Any hospitalization in the past 5 years:
- ☐ Y ☐ N  Any serious illnesses/surgeries:
- ☐ Y ☐ N  Use tobacco in any form?  If Yes, Type:
- ☐ Y ☐ N  Is pre-medication required before dental visits due to heart condition or artificial joint?

### FEMALE PATIENTS:

- ☐ Y ☐ N  Currently nursing?
- ☐ Y ☐ N  Currently pregnant?  Due Date: ____________________________

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  ☐ Y ☐ N  If yes, please describe:

________________________________________________________________________

Is there anything important about your medical condition we have not asked?  ☐ Y ☐ N  If yes, please describe:

________________________________________________________________________
### ALLERGIES/ALLERGIC REACTIONS

**All Patients: Do you have, or have you ever had any of the following?**

(Click all that apply):

- Acid Reflux
- ADHD
- AIDS/HIV
- Anemia
- Anorexia
- Anxiety
- Artificial Heart Valve
- Artificial Joints
- Arthritis
- Asthma
- Autism/Asperger’s
- Bleeding Disorder
- Bulimia
- Cancer/Malignancy
- Convulsions
- Depression
- Dizziness/Fainting
- Epilepsy/Seizures
- Frequent Ear Infections
- Frequent Headaches
- High Blood Pressure
- Kidney Disease
- Liver Problems
- Mitral Valve Prolapse
- Mononucleosis
- Pacemaker
- Other – Please List:

---

**All Patients: Are you ALLERGIC to or have you ever had any reaction to the following?**

(Click all that apply):

- Aspirin
- Anesthetic – Local
- Barbiturates
- Codeine
- Dairy
- Latex
- Lactose Intolerance
- Metal Sensitivity
- Nitrous Oxide Sedation
- Penicillin/Other Antibiotics
- Sleeping Pills

---

### MEDICATION INFORMATION

**All Patients: Are you currently taking any of the following?**

(Click all that apply):

- Antibiotics/Sulfa Drugs
- Blood Thinners
- Insulin
- Recreational Drugs
- OTC Drugs/Medications
- Antihistamines/Allergy
- Cancer/Chemo Medications
- Nitroglycerin
- Thyroid Medications
- Other (please list below)

(please list below)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Reason Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: [Signature]

Date: [Date]

Relationship to Patient: [Adult Patient] [Parent] [Guardian] [Other]

---

**Tel:** 503-665-3116

**60 NW 2nd Street**

**Gresham, OR 97030**

---