

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

Do you have a medical condition that requires you to be pre-medicated before dental treatment? 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/Stroke	Y N	HIV+/AIDS	Y N
Mitral Valve Prolapse	Y N	Shingles	Y N
Heart Murmur/Rheumatic Fever	Y N	Kidney problems	Y N
Hip & Joint Replacement	Y N	Sinus problems	Y N
Heart Surgery/Pacemaker	Y N	Fever Blisters/Herpes	Y N
Chronic Hepatitis	Y N	Psychiatric problems	Y N
Anemia	Y N	Diabetes	Y N
High Blood Pressure	Y N	Tuberculosis (TB)	Y N
Low Blood Pressure	Y N	Sickle Cell Disease	Y N
Severe Headaches	Y N	Thyroid	Y N
Epilepsy/Seizures/Fainting Spells	Y N	Cardiac problems	Y N
Drug/Alcohol Abuse	Y N	Lung problems	Y N
Hemophilia/Abnormal Bleeding	Y N	Neurological problems	Y N
Cancer/Chemotherapy	Y N	Artificial joints or valves	Y N

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
Erythromycin	Y N	Codeine	Y N
Dental Anesthetics	Y N	Metals	Y N
Latex	Y N	Acrylics	Y N
Aspirin	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 status.

Signature

Date