

MEDICAL HISTORY UPDATE

Patient Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

EMERGENCY CONTACT NAME: _____ **PHONE NUMBER:** _____

How would you prefer contact from us? Text Email Home Phone Cell Phone Work Phone

Have you been hospitalized in the last 2 years or had any major operations or serious illnesses? YES NO

If yes, please describe: _____

Allergies _____

Latex Allergy? YES NO

WOMEN ONLY: Are you pregnant or think you may be pregnant? YES NO Breastfeeding? YES NO

Do you currently (or have you ever had) any of the following conditions? (Check all that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joint
(Date _____) | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stomach/Intestinal |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting/Dizzy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke
(Date _____) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Cold Sores | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Autism/Asperger | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lung Disease (COPD) | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Bleeding Disorder
(Anemia, Hemophilia) | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer/Tumor
(Date _____) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis/Liver
Disease | <input type="checkbox"/> Radiation/Chemo | |
| | | <input type="checkbox"/> Respiratory Disease | |
| | | <input type="checkbox"/> Rheumatic Fever | |

Do you currently (or have you ever used) tobacco products? NO YES, currently YES, but no longer
How frequently? _____ CIGARETTE CIGAR SNUFF DIP OTHER

Have you ever taken medications (such as bisphosphonates) that affect bone or to prevent bone disease (ie. Fosamax, Zometa, Actonel, Aredia)? YES NO

If applicable, are you required to take a premedication prior to your dental appointment (ie. joint replacement, history of infective endocarditis)? YES NO

If yes, reason: _____

Are you currently taking any Medications? YES NO **If Yes Please List All Medications Below:**

Drug Name	Dosage	Reason

Please see the attached list of additional current medications

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: _____ **Date:** _____

Relationship to Patient: Self Parent Guardian Other