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):

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

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