MEDICAL HISTORY UPDATE

Patient name_____ Date of Birth_____ Todays Date_____

Address_____ City_____ State_____ 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
- ☐ HPV
- ☐ Kidney
- ☐ 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 _____

Have you been vaccinated for HPV? YES ☐NO

Do you currently (or have you ever used) tobacco? ☐NO ☐YES ☐YES, but no longer

How frequently? _____ ☐Cigarette ☐Cigar ☐Snuff ☐Dip ☐Other

Have you ever taken medication, such as bisphosphonates that affect or prevent bone disease (i.e. Fosamax, Zometa, Actonel, Aredia) ☐YES ☐NO

If applicable, are you required to take premedication prior to your dental appointment (i.e. Joint replacement, history of infective endocarditis)? ☐YES ☐NO

If yes, reason: _____

Are you currently taking any blood thinners (i.e. Warfarin, Heparin, Eliquis) YES ☐NO

Are you currently taking any medications? ☐YES ☐NO **If yes, please list all medications below:**

Drug Name	Dosage	Reason

☐ **Please see 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