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Patient Medical History Update (please complete accurately and legibly)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that assists in your overall health and well-being. If this form contains information from a recent visit, simply correct any errors, add any additional information needed and sign on the last page.

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Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Would you consider your overall health to be:

* ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If there have been any changes in your general health in the past year, please list those changes below:

What is the date (or approximate date) of your last complete physical?

Your Primary Care Physician's name and address, & phone number:

Please check any of the following to indicate a YES in response to the question:

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last year?

☐ Are you taking any Osteoporosis Medication (esp bisphosphonates such as Fosamax, Actonel, Boniva, etc)?

☐ Do you have an active case of tuberculosis or have been exposed to anyone with tuberculosis?

☐ Persistent cough greater than a 3-week duration and/or a cough that produces blood?

☐ Do you use controlled substances or recreational drugs?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are checked, please explain as necessary:

REQUIRED: Emergency Contact Names and Phone#s:

*

Have you ever been told to take an Antibiotic before visiting the Dentist?

* ◯ Yes ◯ No

What Medication are you taking now (please include all prescription and non-prescription medications, including vitamins, natural or herbal preparations and diet supplements):

WOMEN ONLY: If pregnant, what is your due date?

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Please select to indicate each item below that you have and /or are experiencing or have ever been treated for:

- [ ] Acrylic Allergy
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Clotting Pbm
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Bronchitis
- [ ] Cancer
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Valve Replaced
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Immune System Pbm
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease/Pbm
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] NO NITROUS
- [ ] Osteoporosis Meds
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pre Medicate needed
- [ ] Pregnant (Currently)
- [ ] Radiation Treatment
- [ ] Reflux/Heartburn
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] SEE NOTES
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Vertigo/Ear Pbm

IMPORTANT Do you have any other health issues or allergies (include all allergies including but not limited to Penicillin, Codeine, Novocain/Food Allergies/Latex/Acrylic allergies) or need to clarify any of the selected items above? If so, please be detailed:

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature of patient (if 18 or older) and parent/guardian/financially responsible party:

Signature: _____ Date: _____

Relationship to Patient (if signature above is not the patient):

_____

Thank you for taking the time to complete or update your Medical Records.

Response Date: _____