## MEDICAL HISTORY UPDATE

**Last Name:_____First Name:_____Date of Birth_____**

**Please answer ALL of the following questions. Your answers are completely CONFIDENTIAL. This information is important in order to treat you safely and efficiently. Information that is left out or incorrect can be dangerous to your health. Please feel free to discuss any questions or extenuating circumstances with the doctor.**

| DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? | | | |
|---|---|---|---|
| Damaged / Replaced / Artificial heart valves? (Circle one) | ☐ Yes | ☐ No | |
| Heart trouble inc. rheumatic heart disease? | ☐ Yes | ☐ No | Describe: |
| Surgical implants or artificial joints? | ☐ Yes | ☐ No | What kind? When placed? |
| Premedication for dental treatment? | ☐ Yes | ☐ No | Name of medication: |
| Hepatitis A, B, C, D? (Circle letter) | ☐ Yes | ☐ No | When? |
| Jaundice or liver disease? | ☐ Yes | ☐ No | When? |
| Kidney disease or trouble? | ☐ Yes | ☐ No | |
| Stomach ulcers? | ☐ Yes | ☐ No | |
| Tuberculosis (TB)? | ☐ Yes | ☐ No | When? |
| Coughing up blood? | ☐ Yes | ☐ No | |
| Blood disorders? | ☐ Yes | ☐ No | What kind? |
| Bruise easily? | ☐ Yes | ☐ No | |
| Low blood pressure? | ☐ Yes | ☐ No | |
| High blood pressure? | ☐ Yes | ☐ No | |
| Surgery within the past 5 years? | ☐ Yes | ☐ No | What for? |
| Cancer? | ☐ Yes | ☐ No | What kind? When? |
| Radiation or chemotherapy? (Circle one or both) | ☐ Yes | ☐ No | When? |
| Sinus trouble? | ☐ Yes | ☐ No | |
| Hives or skin rash? | ☐ Yes | ☐ No | What causes it? |
| Allergies to medication, anesthetic or food? | ☐ Yes | ☐ No | Name? |
| Asthma? | ☐ Yes | ☐ No | |
| Hay fever or seasonal allergies? | ☐ Yes | ☐ No | |
| Fainting spells or dizziness? | ☐ Yes | ☐ No | |
| Diabetes? | ☐ Yes | ☐ No | When diagnosed? |
| Arthritis or rheumatism? | ☐ Yes | ☐ No | |
| Mental condition or disorder? | ☐ Yes | ☐ No | What kind? |
| Seizures or epilepsy? | ☐ Yes | ☐ No | Date of last seizure? |
| Sexually transmitted disease? | ☐ Yes | ☐ No | What kind? |
| HIV infection? | ☐ Yes | ☐ No | When diagnosed? |
| Are you pregnant? | ☐ Yes | ☐ No | Which month? |
| Are you nursing? | ☐ Yes | ☐ No | |
| Smoking habit? | ☐ Yes | ☐ No | How many pack/day? For how many years? |
| Smokeless or chewing tobacco? | ☐ Yes | ☐ No | |
| Do you use recreational drugs, inc. alcohol? | ☐ Yes | ☐ No | Name? How often? |

**MEDICAL HISTORY UPDATE**

**Last Name:_____First Name:_____Date of Birth_____**

Do you have any disease, condition or problem not listed above that you think your dentist should know about?_____

_____.

Please list any medications that you are taking (include birth control & vitamins):

_____

_____

_____

Have you ever had trouble with previous dental treatment or oral surgery? Please describe.

_____

_____

Name & Address of **Medical** Dr:_____ Preferred Pharmacy: _____

_____ _____

_____ _____

**Emergency Contact_____Phone _____**

**Relationship_____**

**Please print YOUR name**: _____

**Address_____**

**Phone#_____Cell#_____**

**Please notify front desk of any changes in Dental Insurance**.

**I authorize the release of my medical records to this office, if necessary, and grant the right to the dentist to release health information obtained from me, and information about my dental treatment to Third Party Payors and/or other health care practitioners. I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the questions set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in completing this form.**

Date:_____ Patient's (or Parent/Guardian's) Signature:_____

Dentist's Signature:_____