



Medical History Update

Patient Name _____ Date of Birth _____

Telephone: Primary (daytime) _____ Secondary _____

Primary Physician _____ Tel # _____ Date of last visit/physical _____ / _____

Medical Specialist (Ob-gyn, cardiologist, etc) _____ Office Phone _____

Please list the **medications** you are taking: (e.g. birth control, aspirin, antibiotics, pain medications, vitamins, supplements):

Have you **had any allergic reactions** to any foods, latex, medications(including antibiotics) or dental anesthetics? **Yes No**

If the answer above is yes, **what are you allergic to?** _____

Smoke, dip, or chew tobacco ?	Yes No		
Hospitalizations (exc childbirth), surgeries, serious illness	Yes No	Fainting / seizures / epilepsy	Yes No
Arthritis	Yes No	Get tired easily	Yes No
Joint replacement or implants	Yes No	Thyroid problems _____	Yes No
Steroids prescribed in the last 2 years?	Yes No	Liver Disease / jaundice / hepatitis	Yes No
Head, neck or back injuries or problems	Yes No	Kidney problems	Yes No
Recent weight gain or loss	Yes No	Diabetes _____	Yes No
High blood pressure	Yes No	Depression or psychiatric Treatment	Yes No
Low blood pressure	Yes No	Stomach / intestine problems or ulcers	Yes No
Excessive bleeding when cut	Yes No	Sexually transmitted disease	Yes No
AIDS or HIV infection	Yes No	Osteoporosis _____	Yes No
Leukemia / anemia / sickle cell disease	Yes No	Tooth, jaw, head, or neck injuries	Yes No
Rheumatic fever / heart murmur / mitral valve prolapse	Yes No	Frequent headaches /facial muscle pain	Yes No
Heart problems / heart attack / stroke / angina	Yes No	Takes a long time or a lot of dental anesthetic to numb teeth	Yes No
Heart Pacemaker / Stent / Bypass	Yes No		
Chest pains	Yes No	Snoring or sleep apnea	Yes No
Cancer / Radiation / Chemotherapy Treatment	Yes No	History of fever blisters	Yes No
Lung problems, asthma, or Tuberculosis	Yes No	Sinus problems	Yes No
Get out of breath easily	Yes No	Treated by orthodontist, periodontist (gums) or oral surgeon	Yes No
Drug or alcohol abuse	Yes No		
WOMEN ONLY: Are you pregnant? # weeks _____	Yes No	Are you nursing?	Yes No

Patient/Guardian comments or additional conditions: _____

Dentist Comments: _____

I certify that I have read and understand the information on this form. To the best of my knowledge, the questions above have been accurately answered.

Patient/Guardian Signature _____ Date _____ Doctor Signature _____

Patient/Guardian Signature _____ Date _____ Doctor Signature _____

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Patient/Guardian Signature _____ Date _____ Doctor Signature _____

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