MEDICAL HISTORY UPDATE

Patient Name: _____ Birth Date: _____ Age: _____
Last First Middle Initial

Physician Name: _____ Phone Number: _____ Email: _____

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

1. Hospitalization for illness or surgery in last 5 years	Yes	No
2. An allergic reaction	Yes	No
3. Any reaction to:		
a. Aspirin	Yes	No
b. Penicillin	Yes	No
c. Sulfa	Yes	No
d. Erythromycin	Yes	No
e. Tetracycline	Yes	No
f. Codeine	Yes	No
g. Sedatives or sleeping pills	Yes	No
h. Dental anesthetic	Yes	No
i. Any other medication	Yes	No
j. Latex	Yes	No
4. Hepatitis A, B, C	Yes	No
5. Jaundice (yellow skin and eyes)	Yes	No
6. Epilepsy or fainting	Yes	No
7. Arthritis or rheumatism	Yes	No
8. Rheumatic Fever or Scarlett Fever	Yes	No
9. Blood transfusion	Yes	No
10. Anemia or other blood disorders	Yes	No
11. Bleeding or clotting disorders	Yes	No
12. Kidney disease	Yes	No
13. Diabetes Type I or Type II	Yes	No
14. Stomach or duodenal ulcer	Yes	No
15. Liver disease	Yes	No
16. Tuberculosis	Yes	No
17. Emphysema or COPD	Yes	No
18. Thyroid or parathyroid disorders Hyper Hypo	Yes	No
19. Heart Trouble	Yes	No
20. Heart murmur	Yes	No
21. Has your physician recommended pre-medication with antibiotics?	Yes	No
22. Atherosclerosis	Yes	No
23. High blood pressure	Yes	No
24. Low blood pressure	Yes	No
25. Artificial valve or joint placed	Yes	No
26. Cancer	Yes	No
27. Jaw Pain	Yes	No
28. Back problems	Yes	No
29. A stroke	Yes	No
30. Pacemaker or open heart surgery	Yes	No
31. Shortness of breath on mild exertion	Yes	No
32. Chest pains	Yes	No
33. Hives, skin rash, hay fever	Yes	No
34. Asthma or other lung problems	Yes	No
35. Anxiety or depression	Yes	No
36. Psychiatric treatment	Yes	No
37. History of drug or alcohol abuse	Yes	No
38. Tumor or abnormal growth / cancer	Yes	No
39. Radiation treatment	Yes	No
40. Glaucoma	Yes	No
41. HIV	Yes	No
42. AIDS	Yes	No
43. Herpes	Yes	No

ARE YOU:

1. Presently being treated for any illness	Yes	No
2. Now taking any medication	Yes	No
3. Aware of any change in your general health	Yes	No
4. Often exhausted or fatigued	Yes	No
5. Subject to frequent headaches	Yes	No
6. A smoker or using any tobacco products	Yes	No
How much? _____ For How long?		
7. Taking any naturopathic meds or supplements	Yes	No
Fosamax, Actorel, Boniva for osteoporosis		

IF FEMALE, ARE YOU NOW:

1. Pregnant or nursing	Yes	No
2. Taking birth control pills or other hormones	Yes	No
3. Presently in menopause	Yes	No
4. Postmenopausal	Yes	No

IF PATIENT IS A CHILD:
Child's Height: Child's Weight:

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE AND LIST ALL MEDICATIONS - PRESCRIBED, OVER-THE-COUNTER, OR OTHERWISE - THAT YOU TAKE DAILY. *(Use additional sheet if necessary.)*

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

Patient Signature: _____ Date: _____

MEDICAL HISTORY UPDATE

Date:	Reviewed By:	Comments:	Patient Initial:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____