

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 | 28. Back problems | Yes | No |
| 2. An allergic reaction | Yes | No | 29. A stroke | Yes | No |
| 3. Any reaction to: | | | 30. Pacemaker or open heart surgery | Yes | No |
| a. Aspirin | Yes | No | 31. Shortness of breath on mild exertion | Yes | No |
| b. Penicillin | Yes | No | 32. Chest pains | Yes | No |
| c. Sulfa | Yes | No | 33. Hives, skin rash, hay fever | Yes | No |
| d. Erythromycin | Yes | No | 34. Asthma or other lung problems | Yes | No |
| e. Tetracycline | Yes | No | 35. Anxiety or depression | Yes | No |
| f. Codeine | Yes | No | 36. Psychiatric treatment | Yes | No |
| g. Sedatives or sleeping pills | Yes | No | 37. History of drug or alcohol abuse | Yes | No |
| h. Dental anesthetic | Yes | No | 38. Tumor or abnormal growth / cancer | Yes | No |
| i. Any other medication | Yes | No | 39. Radiation treatment | Yes | No |
| j. Latex | Yes | No | 40. Glaucoma | Yes | No |
| 4. Hepatitis A, B, C | Yes | No | 41. HIV | Yes | No |
| 5. Jaundice (yellow skin and eyes) | Yes | No | 42. AIDS | Yes | No |
| 6. Epilepsy or fainting | Yes | No | 43. Herpes | Yes | No |
| 7. Arthritis or rheumatism | Yes | No | | | |
| 8. Rheumatic Fever or Scarlet Fever | Yes | No | ARE YOU: | | |
| 9. Blood transfusion | Yes | No | 1. Presently being treated for any illness | Yes | No |
| 10. Anemia or other blood disorders | Yes | No | 2. Now taking any medication | Yes | No |
| 11. Bleeding or clotting disorders | Yes | No | 3. Aware of any change in your general health | Yes | No |
| 12. Kidney disease | Yes | No | 4. Often exhausted or fatigued | Yes | No |
| 13. Diabetes Type I or Type II | Yes | No | 5. Subject to frequent headaches | Yes | No |
| 14. Stomach or duodenal ulcer | Yes | No | 6. A smoker or using any tobacco products | Yes | No |
| 15. Liver disease | Yes | No | Howmuch? _____ For How long? | | |
| 16. Tuberculosis | Yes | No | 7. Taking any naturopathic meds or supplements | Yes | No |
| 17. Emphysema or COPD | Yes | No | Fosamax, Actonel, Boniva for osteoporosis | | |
| 18. Thyroid or parathyroid disorders Hyper Hypo | Yes | No | IF FEMALE, ARE YOU NOW: | | |
| 19. Heart Trouble | Yes | No | 1. Pregnant or nursing | Yes | No |
| 20. Heartmurmur | Yes | No | 2. Takingbirthcontrolpills or other hormones | Yes | No |
| 21. Has your physician recommended pre-medication with antibiotics? | Yes | No | | | |
| 22. Atherosclerosis | Yes | No | 3. Presently in menopause | Yes | No |
| 23. High blood pressure | Yes | No | 4. Postmenopausal | Yes | No |
| 24. Low blood pressure | Yes | No | | | |
| 25. Artificial valve or joint placed | Yes | No | IF PATIENT IS A CHILD: | | |
| 26. Cancer | Yes | No | Child's Height: Child's Weight: | | |
| 27. Jaw Pain | Yes | No | | | |

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:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____