Patient Medical History Update

Date_____

Name_____Address_____

City_____State_____County_____Zip_____

Home Phone_____ Cell Phone _____Work Phone _____

Married _____ Birthdate _____ Gender _____ Age_____

Social Security #_____ Employer _____

Employers Address _____

Spouse or Guardian information (if patient is under age)

Name _____

Address _____

Birthdate _____Age _____

Social Security #_____

Employer _____

Employer Address_____

Dental Insurance Information (Only)

Subscriber Name_____ Employer Name_____

Insurance Name_____ Subscriber #_____

Insurance Address _____

Insurance Phone # _____

NOTICE TO ALL PATIENTS

Our office requires a 24 hour notice to reschedule.

Failure to do so will result in no more scheduled appointments

Dental / Medical History

Patient Name _____

1, Are you taking any medications? If so, What? (Please attach additional sheet if necessary)

_____ YES / NO

2, Are you allergic to or have had a reaction to any medication or drug? YES / NO

If so, What?_____

3, Have you been under a physician care in the past 2 years? YES / NO

If so, Why? _____

4, Have you been hospitalized in the past 2 years YES / NO

If so, Why? _____

5, Do you have or have you ever had a heart murmur or been treated for a

heart condition in the past 2 years? If so, When _____ YES / NO

6, Have you ever been treated for a tumor, growth, or Cancer? YES / NO

7, Have you ever had excessive or prolonged bleeding?

as a result of a medical condition or medication? YES / NO

(example: Hemophilia or blood thinners)?

8, Do you have a latex allergy? YES / NO

9, Do you have or have ever had a stint, shunt, or artificial joint? YES / NO

10, Women Only: Are you pregnant? YES / NO

If so, Due Date _____

11, Are you now or have ever taken the following medications: Fen-Phen, Redux, Pondimin, Aredia,

Fosamax, Zometa, Actonel, or Boliva? YES / NO

12, Are you now or have ever been treated for Drug Dependency or Alcoholism or taken Narcotics in the last 6 months? YES / NO

If so, what kind? _____

13, Are you now or have been on Narcotics for any reason in the last YES / NO

6 months? if so what kind? _____

Check any of the following that you have had

____ Congenital Heart Defects
____ Heart Attack or Heart Problems
____ Stroke
____ Rheumatic Fever
____ Mitral Valve Prolapse
____ Anemia (Blood Disease)
____ Thyroid Problems
____ Chronic Bronchitis
____ STD (Syphilis, Gonorrhea, Herpes)
____ Angio Edema
____ Epilepsy or Seizures
____ Emphysema
____ Psychiatric Treatment
____ Radiation Therapy
____ Chemotherapy
____ Solid Organ Transplants
____ Stem Cell or Marrow Transplants
____ Arthritis
____ Artificial Heart Valve
____ Hepatitis (___A ___B___C)
____ Any Type of Transplant
____ Steroid Treatments
____ Sickle Cell Anemia
____ Angina
____ High Blood Pressure
____ Heart Pacemaker
____ Diabetes
____ AIDS or HIV Infections
____ Tuberculosis
____ Artificial Joints
____ Asthma
____ Kidney Dialysis
____ Indwelling Catheter
____ Systemic Lupus Erythematosus

Do you have any disease, condition, or problem not listed above? _____

Check any of the following that you have had or applies to you:

____ Sensitive Teeth
____ Bleeding Gums
____ Food Impaction
____ Pain around Ear
____ Tooth Ache
____ Swelling or Lump in Throat / Mouth
____ Unusual Sounds While Eating
____ Snoring
____ Blister on Lips or Mouth
____ Clenching or Grinding
____ Wear Dentures
____ Burning Tongue
____ Bad Breath
____ Decayed Teeth
____ Loose Teeth
____ Wear Partial Dentures

Print Name _____ Signature _____ Date _____