W DENTAL

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MEDICAL HISTORY UPDATE

MEDICAL HISTORY

Patient's Name _____ (_____)
LAST FIRST MI PREFERRED OR NICK NAME

Contact Updates?
Has your address, email or phone changed since we last saw you?

_____ _____
STREET ADDRESS EMAIL

_____ ( ) -
CITY STATE ZIP PHONE NUMBER

For women:
Do you take birth control pills? ❒Yes ❒No Are you pregnant? ❒Yes ❒No If yes, how long?_____ Are you nursing?❒Yes ❒No

What medications are you taking? ❒Nerve pills ❒Pain killers (including aspirin) ❒Muscle relaxers ❒Stimulants ❒Insulin ❒Blood thinners ❒Tranquilizers ❒Osteoporosis Medication ❒Other(s)_____

_____

Have you ever taken: Bisphosphonates (e.g. Aredia/Fosamax) ❒Yes ❒No Phen-fen/Redux ❒Yes ❒No

Do you have or have you had any of the following diseases, medical conditions or procedures?

❒Yes ❒No Heart attack/stroke	❒Yes ❒No Thyroid problems	❒Yes ❒No Cancer/tumors	❒Yes ❒No Cosmetic surgery
❒Yes ❒No Heart surgery/pacemaker	❒Yes ❒No Kidney problems	❒Yes ❒No Shingles	❒Yes ❒No -X-ray/Cobalt treatment
❒Yes ❒No Heart murmur	❒Yes ❒No Liver problems	❒Yes ❒No Hepatitis	❒Yes ❒No Chemotherapy
❒Yes ❒No Rheumatic fever	❒Yes ❒No Respiratory problems	❒Yes ❒No HIV+/AIDS/ARC	❒Yes ❒No Asthma
❒Yes ❒No Mitral valve prolapse	❒Yes ❒No Sinus problems	❒Yes ❒No Arthritis/rheumatism	❒Yes ❒No Difficulty breathing
❒Yes ❒No Artificial valves	❒Yes ❒No Stomach problems/ulcers	❒Yes ❒No Artificial bones/joints	❒Yes ❒No Diabetes/hypoglycemia
❒Yes ❒No Heart disease	❒Yes ❒No Psychiatric problems	❒Yes ❒No Emphysema	❒Yes ❒No Leukemia
❒Yes ❒No Congenital heart defect	❒Yes ❒No Venereal disease	❒Yes ❒No Fainting/seizures/epilepsy	❒Yes ❒No Anemia
❒Yes ❒No Chest pains	❒Yes ❒No Alcohol/drug abuse	❒Yes ❒No Severe/frequent headaches	❒Yes ❒No High/low blood pressure
❒Yes ❒No Scarlet fever	❒Yes ❒No Tuberculosis TB	❒Yes ❒No Frequent neck pain	❒Yes ❒No Bleeding problems
❒Yes ❒No Nervousness	❒Yes ❒No Jaw problems TMJ/TMD	❒Yes ❒No Back problems	❒Yes ❒No Glaucoma

❒Yes ❒No Sleep Apnea / Do you wear a device for Sleep Apnea?_____

Please list any other surgeries or medical conditions you have had _____

_____

Are you allergic to any of the following? ❒Latex ❒Penicillin/Amoxicillin ❒Tetracycline ❒Aspirin ❒Dental Anesthetics

❒Foods_____ ❒Others_____

Do you use tobacco ❒No ❒Yes/how used?_____How much?_____How long?_____

What rating would you give your smile? 1-10 (10 is best) _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Guardian Signature_____ Date _____

Reviewing Dentist Signature _____ Date _____