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# UPDATED MEDICAL HISTORY

Today's Date: ______________

Welcome…The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## ABOUT YOU

**Name:** ____________________________________________ I prefer to be called: ________________
LAST FIRST MI MR MRS MS DR

☐ Male ☐ Female Cell #: ____________________

WK #: ______________ Ext ________ E-mail: ____________________

## MEDICAL HISTORY

**Do you have a preferred physician?** ☐ No ☐ Yes Physician's Name: ____________________

Phone #: ______________

Are you taking daily **ANY** prescriptions / over-the-counter vitamins / supplements? ☐ No ☐ Yes

Please list ____________________________________________

____________________________________________

**Have you ever had any of the following diseases or medical conditions?**

| | | | | | |
|---|---|---|---|---|---|
| Y N | Heart Attack / Stroke | Y N | Artificial Valves | Y N | Hemophilia / Abnormal Bleeding |
| Y N | Cancer / Chemotherapy | Y N | Sinus Problems | Y N | Ulcers / Colitis |
| Y N | Heart Murmur | Y N | High / Low Blood Pressure | Y N | Congenital Heart Defect |
| Y N | Rheumatic Fever | Y N | Fever Blisters | Y N | Anemia / Radiation Treatment |
| Y N | HIV+ / AIDS | Y N | Severe / Frequent Headaches | Y N | Arthritis |
| Y N | Heart Surgery / Pacemaker | Y N | Psychiatric Problems | Y N | Asthma |
| Y N | Shingles | Y N | Epilepsy / Seizures / Faint | Y N | Difficulty Breathing |
| Y N | Mitral Valve Prolapse | Y N | Diabetes / Tuberculosis (TB) | Y N | Hospitalized for Any Reason |
| Y N | Kidney Problems | Y N | Drug / Alcohol Abuse | Y N | Hepatitis |
| Y N | Artificial Bones / Joints | Y N | Venereal Disease | Y N | Blood Transfusion |
| Y N | High Cholesterol | Y N | Gerd/Acid Reflux/Apnea/Wear CPAP(?) | Y N | Emphysema / Glaucoma |
| | | | | Y N | Do you Chew Tobacco / Smoke |
| | | | | Y N | Osteoporosis |

**Please list any recent surgeries or hospitalizations with dates.**

____________________________________________

____________________________________________

**Are you allergic to any drugs / foods?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y N | Penicillin | Y N | Erythromycin | Y N | Dental Anesthetics | Y N | Latex |
| Y N | Aspirin | Y N | Tetracycline | Y N | Codeine | Y N | Other |

Please list any other drugs / foods that you are allergic to: ____________________

____________________________________________

**Dental:** How often do you brush? ______________ How often do you floss? ______________

Do your gums bleed? Y N Do you have tooth sensitivity? Y N Dry Mouth? Y N

**For Women**

Are you taking birth control pills? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes

Week # ______________ Are you nursing? ☐ No ☐ Yes

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.*

Signature ______________________________ Date ______________

## Office Use Only

**Medical History Review & Update**

I have reviewed the medical / dental information above with the parent / guardian and patient named herein.

| Date | Signature | Date | Signature |
| --- | --- | --- | --- |
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