# MEDICAL HISTORY UPDATE FORM

Although dental personnel primarily treat problems in and around your mouth, your mouth is a part of your entire body. Health problems that you have currently or have had in the past, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for taking time to answer the following questions.

Are you under a physician's care at this time? ☐YES ☐NO

If yes, please explain: ______________________________

Have you ever been hospitalized or had a major operation? ☐YES ☐NO

If yes, please describe and give approximate dates: ______________________________

Are you taking any medications, pills, drugs, or herbal supplements? ☐YES ☐NO
If yes, please list them below:

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Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐YES ☐NO

If yes, please explain: ______________________________

Do you use any form of tobacco? ☐YES ☐NO

If yes, please explain: ______________________________

**Women:** are you currently ☐pregnant or trying to get pregnant ☐taking birth control ☐nursing

Are you allergic to any of the following? ☐Aspirin ☐Penicillin/Amoxicillin ☐Sulfa ☐Clindamycin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other ______________________________

Do you have or have you had any of the following:

☐ AIDS/HIV
☐ Alzheimer's
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve *
☐ Artificial Joint *
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pain
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder *
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur *
☐ Heart Pacemaker *
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives/Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse *
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever *
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Snoring/Sleep Apnea
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

** Condition may require premedication or physician clearance prior to dental treatment.*

Have you ever had any serious illness or condition not listed above? ☐YES ☐NO

If yes, please explain: ______________________________

Has your address changed? ☐YES ☐NO
If yes, please write your new address:

______________________________

______________________________

Has your insurance changed? ☐YES ☐NO
If yes, please list the following:

Employer: ______________________________

Insurance Company: ______________________________

Emergency Contact Name: ____________________ Relationship: ____________________ Phone #: ____________________

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's Name (Print): ____________________ Patient's Signature: ____________________ Date: ____/____/______

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