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MEDICAL HISTORY UPDATE

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ ___-___
City State Zip Code

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Cat Dander	☐ Allergy - Codeine
☐ Allergy - Dyes	☐ Allergy - Erythro	☐ Allergy - Hay Fever	☐ Allergy - Iodine
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Thinner	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Factor 5 Deficiency
☐ Fainting	☐ Glaucoma	☐ Head Injuries	☐ Headaches
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Low Blood Pressure	☐ Mental Disorders	☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems
☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease		

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____
_____
_____
_____

Allergies not listed:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *
◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Signature _____ **Date** _____

Response Date: _____