

Patient Name \_\_\_\_\_

last

first

m.i.

1. Name, address and phone of physician \_\_\_\_\_

2. Date of last physical exam \_\_\_\_\_

3. Are you currently under the care of a doctor for a specific disease or condition?

Explain \_\_\_\_\_

4. Have you been hospitalized or had a serious illness or operation in the past 5 years?

Explain \_\_\_\_\_

5. Do you now or have you ever had any of the following diseases or problems? Circle:

- |                          |                    |                            |                   |
|--------------------------|--------------------|----------------------------|-------------------|
| Rheumatic Fever          | Hepatitis          | Diabetes                   | Anemia            |
| Scarlet Fever            | Liver Disease      | Thyroid Disease            | Hemophilia        |
| Congenital Heart Lesions | Yellow Jaundice    | Chemotherapy               | Blood Transfusion |
| High Blood Pressure      | Artificial Joint   | Radiation Therapy          | Alcoholism        |
| Heart Attack             | Stroke             | Rheumatism / Arthritis     | Drug Dependency   |
| Angina Pectoris          | Kidney Trouble     | History of Fen-Phen Use    | AIDS              |
| Artificial Heart Valve   | Allergies or Hives | Fainting Spells / Seizures | HIV Positive      |
| Pacemaker                | Emphysema          | Psychiatric Treatment      |                   |
| Heart Surgery            | Tuberculosis       | Cold Sores / Herpes        |                   |
| Mitral Valve Prolapse    | Asthma             | Ulcers                     |                   |
| Heart Murmur             | Sinus Troubles     | Eating Disorders           |                   |

6. Are you currently taking ANY drugs or medications? Please list: \_\_\_\_\_

7. Are you allergic to or have you had adverse reactions to any drugs, medications or anesthetics?

Please list: \_\_\_\_\_

8. Have you had abnormal bleeding associated with extractions, surgery or trauma? YES NO

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? YES NO

10. Do your ankles swell during the day? YES NO

11. Do you use more than 2 pillows to sleep? YES NO

12. Do you ever wake up from sleep short of breath? YES NO

13. Have you lost or gained more than 10 pounds in the last year? YES NO

14. Are you on a special diet? YES NO

15. Women: Is there any possibility that you are pregnant? YES NO

Are you practicing birth control? YES NO

16. Do you have any disease, condition or problem not listed above? YES NO

Explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor or hygienist at the next appointment.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

**OFFICE USE ONLY**

**MEDICAL HISTORY UPDATE**

**OFFICE USE ONLY**

Date	Changes	Patient Sig.
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**MEDICAL HISTORY**