PLEASE UPDATE YOUR MEDICAL HISTORY

NAME: ________________________________TODAY'S DATE: ____________________

Please mark with an (X) Yes or No to each question. If unsure of a question, please consult with the dentist.

	YES	NO
1) Are you being treated for any medical condition at present or within the past two years? if yes explain___________________________Physician:____________________phone:__________________	__	__
2) Have you been hospitalized in the past two years?	__	__
3) When was your last visit to a Physician?___________Last complete physical examination?___________		
4) Have you recently, or are you presently taking any prescription or non-prescription drugs (incl. herbal) _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________ _____________________________	__	__
5) Have you ever reacted adversely to any medications or injections? (Check YES or NO and Circle Applicable) e.g. Penicillin, or other antibiotics, aspirin, codeine, local anesthetic (freezing), nitrous oxide, or any other medicine: ____ ____		
6) Have you ever been advised against taking any specific type of medication?	__	__
7) Do you have any of the following? Asthma, hay fever, food allergies, metal or latex allergies, skin rashes? (Check YES or NO and Circle Applicable)	__	__
8) Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? (Check YES or NO and Circle Applicable)	__	__
9) Is there a family history of Diabetes, Cancer or Heart Disease? (Check YES or NO and Circle Applicable)		
10) Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	__	__
11) Do your ankles, feet or hands swell?	__	__
12) Has your weight, appetite or energy level changed dramatically recently?	__	__
13) Do you follow a special diet, or are you on a diet pill therapy? Details: ____	__	__
14) Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	__	__
15) Have you tested HIV positive?	__	__
16) Have you ever had any injury or surgery to your face or jaws?	__	__
17) Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	__	__
18) Do you wear eyeglasses or contact lenses?	__	__
19) Do you have any hearing difficulties?	__	__
20) Do you smoke or use any forms of tobacco?	__	__
a) Are you wearing the transdermal nicotine patch?	__	__
21) Are you alcohol and/or drug dependent?	__	__
	__	__

22) INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

AIDS
ANEMIA
ANGINA PECTORIS
ARTHRITIS/RHEUMATISM
ARTIFICIAL HEART VALVE
ARIFICIAL JOINTS (HIP/KNEE)
ASTHMA
BLOOD DISORDERS
BRONCHITIS
CANCER
CIRCULATION PROBLEMS
CONGENITAL HEART LESIONS
CORSTISONE/STEROID
CRHON'S DISEASE
DIABETES
EMPHYSEMA
EPILEPSY OR SEIZURES
FAINTING OR DIZZY SPELLS
GLANDULAR DISORDES
GLAUCOMA
HEAD/NECK INJURIES
HEART DISEASE OR ATTACK
HEART MURMUR
HEART PEACEMAKER
HEART RHYTHM DISORDER
HEART SURGERY
HEPATITIS A B C ____________
HERPES
HIGH/LOW BLOOD PRESSURE
HODGKINS DISEASE
HYPER (HYPO) GLYCEMIA
HYPERTENSION
iNFLAMMATORY BOWEL DISEASE
JAUNDICE
KIDNEY DISEASE
LIVER DISEASE
LUNG DISEASE
LUPUS
MALIGNANT HYPERTHERMIA
MENTAL/NERVOUS DISORDER
MITRAL VALVE PROPLAPSE
ORGAN TRANSPLANT/MEDICAL IMPLANT
PSYCHRIATRIC TREATMENT
RADIATION TREATMENT/CHEMOTHERAPY
SCARLET FEVER----RHEUMATIC FEVER
SICKLE CELL DISEASE
SINUS TROUBLE
STOMACH/INSTESTINAL PROBLEMS/ ULCERS
STROKE
THYROID DISEASE
TUBERCULOSIS
VENEREAL DISEASE
OTHER

23) Has the CHILD PATIENT recently had any of the following:
indicate approximate date:
MEASLES ___________
MUMPS ___________
CHICKEN POX __________
STREP THROAT __________
TONSILITIS __________

24) Do you currently have, or have you had in the past any disease or condition not li
25) Is there anything else about your health we should be aware of?______________
26) Do you wish to speak PRIVATELY to the doctor about any problem or medical con
27) WOMEN ONLY:
Are you pregnant or maybe?:______________if yes expected delivery date:_____
Are you breast feeding?__________________Are you taking birth control pills?__

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

PATIENT'S SIGNATURE____DATE:________________________

REVIEWED BY TREATING DENTIST:_____________________________DATE:________________________________