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.

Question	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:____________________

I authorize release, to my benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named Dentist.

This authorization shall continue in effect until undersigned revokes same.

______________________________	______________________________
Signature of patient parent or Guardian	Date