

Date: \_\_\_\_\_

### MEDICAL HISTORY UPDATE

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent(s)/Guardian: \_\_\_\_\_ Driver License/SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

1. Name of Physician? \_\_\_\_\_
2. Date of last medical exam? \_\_\_\_\_
3. Are you under the care of a physician? Why? \_\_\_\_\_
4. Are you taking any medications? List \_\_\_\_\_
5. Do you need Pre-Med (antibiotics) before dental treatment? \_\_\_\_\_
6. Do you or have you ever had any of the following:

	Yes	No		Yes	No
Heart Disease	_____	_____	Aids (HIV)	_____	_____
High Blood Pressure	_____	_____	Rheumatic Fever	_____	_____
Stroke	_____	_____	Hepatitis Type__	_____	_____
Artificial Valve, Joints	_____	_____	Ulcer	_____	_____
Respiratory Problems	_____	_____	Abnormal bleeding	_____	_____
Diabetes	_____	_____	Mental Disorders	_____	_____
Epilepsy	_____	_____	Cancer	_____	_____
Allergies to medicine	_____	_____	Radiation Treatment	_____	_____
Pregnancy	_____	_____	Tuberculosis	_____	_____

7. Are you allergic to any medications? List \_\_\_\_\_
8. Have you had any recent surgery, or been hospitalized? \_\_\_\_\_
9. Is there anything else we should know about your medical history? \_\_\_\_\_
10. Has your insurance information been changed? \_\_\_\_\_

\_\_\_\_\_  
Signature