PATIENT MEDICAL HISTORY & UPDATE FORM

Today's Date:

Name:

Address:

City, State, Zip Code:

Home Phone:

Email:

Work Phone:

Can we email or text you to confirm your appointments?
_____Yes _____ No
If yes, *email only* _____ *text only*_____ *both* _____

Cell Phone:

What is the best way to reach you in case of an emergency?

Primary Dental Insurance Company:

Secondary Dental Insurance Company:

Primary Care Physician Name:

Primary Care Physician Phone:

Pharmacy Name:

Pharmacy Phone:

Emergency Contact Name:

Emergency Contact Phone:

Y	N	Conditions
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Bleeding/Clotting Problems
☐	☐	Blood Disease
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Chemical Dependency
☐	☐	Circulatory Problems
☐	☐	Cold Sores
☐	☐	Cough Up Blood
☐	☐	Cough, Persistent
☐	☐	Diabetes
☐	☐	Eating Disorder
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Head/Neck Injury

Y	N	Conditions
☐	☐	Headaches
☐	☐	Heart Murmer
☐	☐	Heart Problems
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Jaw Pain
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Nervous Problems
☐	☐	Pacemaker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Respitory Problem
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Shortness Of Breath
☐	☐	Sinus Problems
☐	☐	Steroid Treatments
☐	☐	Stroke
☐	☐	Swollen Feet/Ankles

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tobacco Habit
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Do you smoke or use tobacco?
___(Y) ___(N)

Women Only

Are you taking Birth Control?
___(Y) ___(N)

Are you pregnant?
___(Y) ___ (N)

If yes, how many weeks?
_____

Are you nursing?
___ (Y) ___(N)

PLEASE LIST ALL CURRENT MEDICATIONS & DOSAGES:

Have you had any serious illnesses or operations? ___(Y) ___(N) If yes, please describe:

Signature:

OFFICE USE ONLY:

Premed:_____

_____

_____

_____

Script_____

_____

_____

_____

_____

_____