MEDICAL HISTORY UPDATE

PATIENT NAME	PATIENT ACCOUNT NO.

		YES	NO
1.	Are you in good health now?	☐	☐
2.	Are you now under the care of a physician? If yes, why?	☐	☐
3.	History of rheumatic heart disease or heart murmur?	☐	☐
4.	Artificial joint?	☐	☐
5.	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
6.	(Women) Are you pregnant? If so, give due date _____	☐	☐
7.	(Women) Are you breast feeding?	☐	☐
8.	Do you use tobacco in any form? If so, how much? _____	☐	☐

Allergic reactions or drug allergies: *Please list below.*

_____ _____ _____ _____

	YES	NO
Eruptions (rash) hives	☐	☐
Glaucoma	☐	☐
Loss of hearing	☐	☐
Ringing in ears	☐	☐
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Fainting	☐	☐
Psychiatric treatment	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐

	YES	NO
Asthma/hay fever	☐	☐
Persistent cough or sore throat	☐	☐
Difficulty breathing while lying down	☐	☐
Diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐

	YES	NO
Back or neck problems	☐	☐
Arthritis/rheumatism	☐	☐
Hepatitis	☐	☐
Ulcers	☐	☐
Kidney disease	☐	☐
Venereal disease	☐	☐
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
A.I.D.S.	☐	☐
H.I.V. positive	☐	☐
Other _____		

Names of medications and purpose you are now taking:

_____ _____ _____ _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian signature _____ *Date* _____