

MEDICAL HISTORY UPDATE

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

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

- | | YES | NO | | YES | NO | | YES | NO |
|-----------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| Eruptions (rash) hives..... | <input type="checkbox"/> | <input type="checkbox"/> | Asthma/hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Back or neck problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough or sore throat | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing while lying down.... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringling in ears | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid condition/goiter | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/discomfort | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/trouble | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> | A.I.D.S. | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve | <input type="checkbox"/> | <input type="checkbox"/> | H.I.V. positive | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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 _____