

**Medical History Update**

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

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY**Patient Information**Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
Last, First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile Phone/Pager: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

E-mail: \_\_\_\_\_

**Employment or School Information**The following is for:  employment  school if patient is a student

Employer (School) Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone**Any changes to your dental insurance?**  Yes  No Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_**Health Information**

- Are you allergic to any of the following (please check all that apply):  Yes  No  
 Penicillin;  Tetracycline;  Sulfa Drugs;  Aspirin;  Codeine;  Latex;  Metals;  Dental Anesthetics;  Other

**Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.**

- | Y N   | Y N   | Y N   | Y N  |
|---|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Anemia                | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Cancer              | <input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> <input type="checkbox"/> Growths/Tumors      | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures  |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Asthma              | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy        | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders  |
| <input type="checkbox"/> <input type="checkbox"/> Stroke                | <input type="checkbox"/> <input type="checkbox"/> Allergies           | <input type="checkbox"/> <input type="checkbox"/> Hepatitis Type:     | <input type="checkbox"/> <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems      | <input type="checkbox"/> <input type="checkbox"/> Jaundice            | <input type="checkbox"/> <input type="checkbox"/> Depression         |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Diabetes            | <input type="checkbox"/> <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction     |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> <input type="checkbox"/> Head Injuries      |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> <input type="checkbox"/> Rheumatism          | <input type="checkbox"/> <input type="checkbox"/> Cold Sores         |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris       | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily       | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> <input type="checkbox"/> TMJ                |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion     | <input type="checkbox"/> <input type="checkbox"/> Ulcers              | <input type="checkbox"/> <input type="checkbox"/> Arthritis           | <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints |

- Do you have any other health problems or conditions?  Yes  No  
If yes, please explain: \_\_\_\_\_

- Are you taking any medications at this time?  Yes  No  
If yes, please list: \_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past year?  Yes  No  
If yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- Do you smoke?  Yes  No • Have you ever taken any diet drugs such as Phen-Phen, Redux, other?  Yes  No

- Women: are you pregnant now?  Yes, Due Date: \_\_\_\_\_  No • Do you take any birth control medication?  Yes  No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

√ \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient, parent or guardian