



## Patient Medical History Update

**1. Have there been any changes in your health since last visit?**  YES  NO  
 (recent surgeries, hospitalizations)

*If no changes, sign and date the form*

**2. Are you taking medications regularly?**  YES  NO

*Please list names and amount:*

_____	_____
_____	_____
_____	_____

**3. Women: Are you pregnant?**  YES  NO

**4. Check all conditions that apply:**

- |  |   |   |
|--|---|---|
| <input type="radio"/> Heart Murmur   | <input type="radio"/> Blood Disease or Anemia       | <input type="radio"/> Hepatitis, Liver Disease  |
| <input type="radio"/> Mitral Valve Prolapse  | <input type="radio"/> Joint Replacement             | <input type="radio"/> Rheumatic Fever           |
| <input type="radio"/> Heart Disease or Heart Attack                                  | <input type="radio"/> Diabetes                      | <input type="radio"/> Organ Transplant          |
| <input type="radio"/> Stroke   | <input type="radio"/> Herpes                        | <input type="radio"/> HIV positive or AIDS      |
| <input type="radio"/> Fainting or Seizures   | <input type="radio"/> Asthma                        | <input type="radio"/> Tobacco Usage             |
| <input type="radio"/> Lung Disease   | <input type="radio"/> Tuberculosis                  | <input type="radio"/> Thyroid or Gland Disease  |
| <input type="radio"/> <u>High</u> or <input type="radio"/> <u>Low</u> Blood Pressure | <input type="radio"/> Angina                        | <input type="radio"/> Gastrointestinal Disorder |
| <input type="radio"/> Immune System Disorder   | <input type="radio"/> Bleeding or Clotting Problems | <input type="radio"/> Other _____               |

**5. Have you ever reacted adversely to:**

	Reaction		Reaction
<input type="radio"/> Penicillin	_____	<input type="radio"/> Latex	_____
<input type="radio"/> Codeine	_____	<input type="radio"/> Aspirin	_____
<input type="radio"/> Demerol	_____	<input type="radio"/> Antihistamines	_____
<input type="radio"/> Barbiturates	_____	<input type="radio"/> Novocaine	_____
<input type="radio"/> Darvon	_____	<input type="radio"/> Anesthetics	_____
<input type="radio"/> Sulfa	_____	<input type="radio"/> Other	_____

**6. Please list any changes to:**

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**7. Please complete:**

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**8. Insurance changes?** (Please present dental card)

I certify that the above is true and correct to the best of my knowledge.

Signature of Patient/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Print Patient Name \_\_\_\_\_ Social Security \_\_\_\_\_