CIVILS
Doctors of General and Cosmetic Dentistry

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:

○ Heart Murmur	○ Blood Disease or Anemia	○ Hepatitis, Liver Disease
○ Mitral Valve Prolapse	○ Joint Replacement	○ Rheumatic Fever
○ Heart Disease or Heart Attack	○ Diabetes	○ Organ Transplant
○ Stroke	○ Herpes	○ HIV positive or AIDS
○ Fainting or Seizures	○ Asthma	○ Tobacco Usage
○ Lung Disease	○ Tuberculoses	○ Thyroid or Gland Disease
○ High or ○ Low Blood Pressure	○ Angina	○ Gastrointestinal Disorder
○ Immune System Disorder	○ Bleeding or Clotting Problems	○ Other _____

5. Have you ever reacted adversely to:

	Reaction		Reaction
○ Penicillin	_____	○ Latex	_____
○ Codeine	_____	○ Aspirin	_____
○ Demerol	_____	○ Antihistamines	_____
○ Barbiturates	_____	○ Novocaine	_____
○ Darvon	_____	○ Anesthetics	_____
○ Sulfa	_____	○ 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

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This information is strictly confidential - Dr. Civils' office is HIPAA compliant