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Patient Medical History Update Form

Date _____
Dentist's Name _____
Patient Name _____
Social Security Number _____
Date of Birth _____**Ht** _____**Wt** _____**lbs**

Please Check Appropriate Answers

Yes	No	
☐	☐	Are you under medical treatment now? Name and phone number of Physician_____
☐	☐	Are you in good health?
☐	☐	Date of last Physical Examination by a Physician _____
☐	☐	Have you ever been hospitalized or had a serious medical condition within the last five years?
☐	☐	Are you taking any medications including non-prescription medicine? If yes, what medication (s) are you taking? _____
☐	☐	Have you ever taken Phen-Fen, Redux, Fosomax, Actonel, Aredia, Boniva, Zometa?
☐	☐	Do you use Tobacco?
☐	☐	Do you use controlled substances?
☐	☐	Are you wearing contact lenses?
☐	☐	**Are you allergic to or have you had any reactions to the following?**
☐	☐	Local Anesthetic (For example Lidocaine, Novocain)?
☐	☐	Penicillin or any other Antibiotics?
☐	☐	Sulfa Drugs?
☐	☐	Barbiturates?
☐	☐	Benzodiazepines or Narcotics (For example Valium, Xanax, Demerol, Morphine or Codeine)
☐	☐	Iodine?
☐	☐	Aspirin?
☐	☐	Any metals? (For Example nickel, mercury etc)
☐	☐	Latex Rubber?
☐	☐	Other? _____
Women Only:		
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	**Are you taking oral contraceptives? _____**

Patient Dental History

☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Are your teeth sensitive to sweet or sour liquids/foods/?
☐	☐	Do you feel pain to any of your teeth?
☐	☐	Have you had any head, neck or jaw injuries?
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth

Have you ever experienced any of the following problems with your jaw?

Yes	No	
☐	☐	Clicking
☐	☐	Pain (joint, ear side of face)
☐	☐	Difficulty in opening or closing

☐ ☐ Have you ever had any difficult extractions in the past?
☐ ☐ Have you ever had any prolonged bleeding following extractions?
☐ ☐ Have you had any orthodontic treatment?

Do you have or have you had any of the following?

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Rheumatic Fever
☐	☐	Swollen Ankles
☐	☐	Fainting Spells/ Seizures
☐	☐	Abnormal Bleeding
☐	☐	Asthma
☐	☐	Epilepsy/Convulsions
☐	☐	Leukemia
☐	☐	Diabetes
☐	☐	Kidney Disease
☐	☐	Aids or HIV infection
☐	☐	Thyroid problem
☐	☐	Heart Disease
☐	☐	Cardiac Pacemaker
☐	☐	Anemia
☐	☐	Frequently Tired
☐	☐	Angina
☐	☐	Asthma or Emphysema
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Joint replacement or Implant
☐	☐	Hepatitis
☐	☐	Jaundice
☐	☐	Stomach Troubles/Ulcers
☐	☐	Chest Pain
☐	☐	Easily Winded
☐	☐	Stroke
☐	☐	Hay Fever/Allergies
☐	☐	Tuberculosis
☐	☐	Radiation Therapy
☐	☐	Glaucoma
☐	☐	Recent Weight Loss or Gain
☐	☐	Liver Disease
☐	☐	Kidney Disease
☐	☐	Heart Murmur or heart valve replacement
☐	☐	Heart Trouble
☐	☐	Respiratory Problems
☐	☐	Mitral Valve Prolapse
☐	☐	Other _____
☐	☐	Do you wear dentures or partials?

Authorization and Release
I have certified that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or health practioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ Signature of patient (or parent if minor)

Doctor's comments_____

Signature _____ Date _____