MEDICAL HISTORY UPDATE

PATIENT NAME:____

PHONE NUMBER : HOME______________________CELL______________________WORK___________________

ALTERNATE / EMERGENCY CONTACT NAME ________________________PHONE NUMBER: ________________

CURRENT ADDRESS: ____

E-MAIL ADDRESS: ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - PLEASE CIRCLE ALL THAT APPLY TO YOU.

ALLERGIES to latex / drugs / anesthetic list: __________________________________

PREMEDICATE FOR DENTAL PROCEDURES:: Yes / No Reason: _________________________________

Heart Attack : year ________

High Blood Pressure

Pacemaker

Heart Valve Replacement / defect type:_______________

Arrhythmia

Diabetes

Osteoporosis / Osteopenia

Thyroid disease: hypo or hyper

Asthma

Sinus Problem

Nasal Septum defect or surgery

Gastric Ulcer / Acid Reflux

Taking blood thinner for

Anemia ____________________

Excessive bleeding from cuts or extractions

Covid 19

Hepatitis A or B or C

HIV/AIDS

Tuberculosis

Arthritis

Hip or Joint Replacement of ______________year____

Kidney problem ________________________

Seizure (Epilepsy)

Stroke: year__________

Glaucoma

Anxiety / Depression / Bipolar

Cancer of ______________________, currently on Chemo or Radiation treatments for ___________________________

Currently Pregnant, if so due date ___________________

History of Chemical Dependency type ____________________________

-Since last dental visit: * did you have any SURGERIES: ____

*or / and new diagnosed MEDICAL CONDITIONS: ______________________________________

List All Current Medication that you are taking including over the counter meds/herbal meds:

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SIGNATURE____DATE________________________
(Parent or guardian if patient is a minor)

Reviewed by ________________________ form 5/2020