Medical History Update

Name **Date**

Home Address **Home Phone** **Cell phone**

City/State **Zip**

Employer **Work Phone**

Dental Insurance **Secondary**

Date of Birth **SS#**

Confirm via email? **Email Address**

List of Current Medications

Allergic to Any Drugs (please circle)

Local anesthetics Aspirin Insulin Codeine Penicillin

Barbiturates Sulfa Any Other?

Circle any illnesses you have had since you were last in our office

AIDS/HIV Heart Attack Heart Disease High Blood Pressure Low Blood Pressure

Rheumatic Fever Heart Murmur Mitral Valve Prolapse Shortness of Breath Hepatitis

Abnormal Bleeding Diabetes Asthma Tuberculosis Pacemaker

Sinusitis Epilepsy Latex Allergy Cancer or Tumor Jaw Pain

Chronic Fever Blisters Thyroid Problems Joint Replacement Arthritis

Any Other Conditions not Listed

Have you ever fainted from an injection or having blood drawn?

Have you been advised that you have any condition that requires an antibiotic before your dental visit?

Is there any other information we need to know about your previous dental treatment? If so, please explain.

Women: Are you pregnant? **Are you on oral contraceptives?**

To the best of my knowledge, the above is true.

Patient or Guardian Signature