Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have ever had any of the following? Please check those that apply:**

( ) Allergies/Hay Fever

( ) Anemia

( ) Arthritis

( ) Artificial Joints\* (Rods, Fusions, Pins)

( ) Artificial Heart Valve\*

( ) Asthma

( ) Bleeding disorders

( ) Breathing Problems

( ) Cancer

( ) Chemical Dependency

( ) Chemotherapy

( ) Diabetes

( ) Endocarditis\*

( ) Epilepsy or Seizures

( ) Fainting or Dizziness

( ) Fever Blisters/Cold Sores

( ) Glaucoma

( ) Heart Disorder (Congenital)\*

( ) Heart Infection\*

( ) Heart Murmur\*

( ) Heart Pace Maker\*

( ) Heart Surgery\*

( ) Hepatitis

( ) High Blood Pressure

( ) HIV\*/AIDS

( ) Kidney Problems

( ) Liver Problems

( ) Mental Disorders

( ) Mitral Valve Prolapse\*

( ) Osteoporosis (Bisphosphonates or any other Osteoporosis medication)

( ) Radiation Therapy

( ) Respiratory Problems

( ) Rheumatic Fever

( ) Rheumatism

( ) STD

( ) Sickle Cell Disease

( ) Sinus Problems

( ) Stroke

( ) Surgical Shunt\*

( ) Thyroid Problems

( ) Tuberculosis

( ) Ulcers

( ) Yellow Jaundice

( ) Other Conditions Not Listed

***\*This condition may require antibiotic premedication for certain dental procedures.\****

**Yes No**

( ) ( ) Do you have any health problems that were not listed above or need further clarifications? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) ( ) Are you now under the care of a physician? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) ( ) Are you taking any medications or herbals (prescriptions or over the counter, i.e., aspirin)? Please list all medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) ( ) Are you allergic to any medications or substances? If yes, please check box below:

( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Iodine ( ) Latex ( ) Other

**Women (Please check):** ( ) Pregnant ( ) Trying ( ) Nursing ( ) Taking oral contraceptives

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History Update**

**Date Comments Dr. Initials**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_