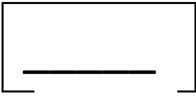

Medical History Update:

Medications currently taking: ☐ None ☐ Insulin ☐ Blood Thinners (including aspirin) ☐ Muscle relaxers ☐ Pain Killer

____

____

Have you ever taken: Osteoporosis Meds (ex. Aredia/Fosamax) ☐ Yes ☐ No

Surgery and Medical Conditions: ☐ None ____

Have you ever had a prosthetic repair to your heart? ☐ Yes ☐ No

Y N Heart Attack/Stroke
Y N Heart Surg./Pacemaker
Y N Heart Murmur
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N High/Low Blood Pressure
Y N Bleeding Problems
Y N Anemia
Y N Cancer
Y N Chemotherapy
Y N Radiation Therapy
Y N Artificial Joints
Y N Arthritis/ Rheumatism
Y N Thyroid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Hepatitis
Y N Asthma
Y N Emphysema
Y N Tuberculosis
Y N Sinus Problems
Y N Stomach Ulcers
Y N Jaw Problems
Y N Severe Frequent Headaches
Y N Drug Abuse
Y N Seizures/ Epilepsy
Y N HIV+/AIDS/ARC
Y N Psychiatric diagnosis
Y N Diabetes

Allergies: ☐ None ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Seasonal ☐ Food ______________

____

Do you use tobacco? ☐ Yes ☐ No Type ______________________________

Are you currently under the care of a Physician? ☐ Yes ☐ No

Physician ____ Phone # _______________________

Emergency Contact _________________________________ Phone # ______________________

Has your dental insurance changed in the last 6 months? ☐ No ☐ Yes ☐ No Insurance

For Women:

Are you pregnant? ☐ Yes ☐ No duration___________ nursing ☐ Yes ☐ No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name ________________________________ Email Address ________________________________

Current Address ________________________________ Phone _____________________

Signature ____________________________________ Date ____/_____/_____