Medical History Update

Last Name: First Name: Birthdate:

Email Address: _____ Cell Phone: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

Please check all medications that you currently taking on the list
and add any additional medications:

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

Do you take a premedication prior to dental treatment? _____

Are you allergic to any of the following?

Y		Y	
☐	Latex	☐	Penicillin/Amoxicillin
☐	Aspirin	☐	Sulfa
☐	Codeine	☐	Ibuprofen
☐	Other:_____		

Do you have any of the following medical conditions?

Y		Y		Y	
☐	Asthma	☐	Kidney Disease	☐	Frequent Headaches
☐	Bleeding Problems	☐	Liver Disease	☐	Osteoporosis/Osteopenia
☐	Cancer	☐	Pregnancy	☐	Radiation Treatment
☐	Diabetes Type I or II	☐	Psychiatric Treatment	☐	Hepatitis
☐	Heart Murmur	☐	Sinus Trouble		
☐	Heart Trouble	☐	Stroke		
☐	High Blood Pressure	☐	Ulcers		
☐	Joint Replacement	☐	Rheumatic Fever		

List any other conditions: _____

Any other significant medical conditions? _____

Recent Surgery: _____

Do you use tobacco? What kind? _____

Reason for today's visit _____ Are you in pain? _____

Date: 05/11/2020

Patient Signature: _____