



# Medical Health History

**Do you have, or have you had, any of the following?**

	Yes	No
Heart Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleed.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia).....	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion?.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Special diet.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement.....	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands.....	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Tumor).....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day.....	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time.....	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much?.....		
Do you smoke or use smokeless tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much?.....		
Hepatitis, jaundice, or liver trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD.....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
HIV positive/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe:.....		

**Are you allergic, or have you reacted adversely, to any of the following?**

	Yes	No
Local anesthetic (Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber gloves.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....		

**During the past 12 months, have you taken any of the following:**

	Yes	No
Antibiotics or sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (i.e., Coumadin).....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine.....	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers.....	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin.....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids).....	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies.....	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....		

**Women**

Are you taking oral contraceptives or other hormones?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date.....		
Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms?.....		

**PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY.**

The above information is true and complete to the best of my knowledge. I agree to pay my co-payment at the time services are rendered. The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** (Parent's signature, if a minor) \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Information Update Slip**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Telephone Number Home \_\_\_\_\_

Work \_\_\_\_\_

Cell # \_\_\_\_\_

**Has there been any change in your medical history since your last visit to our office? YES I NO**

**Are you currently taking any medication YES / NO**

Please list each medication:

_____	_____
_____	_____
_____	_____

**Are you allergic to any medications YES / NO**

Please list each medication:

_____	_____
_____	_____
_____	_____

**Do you have "Dental Insurance"? YES / NO**

\*\*\*\*\*Need Copy of Card\*\*\*\*\*

**Has your insurance changed since your last visit? YES / NO**

**Name of dental personnel updating this history: \_\_\_\_\_**

**\*\*\*Please complete back of this page\*\*\***