Medical Update

Patient Name:_____ **Date:**_____

Has your address or phone number(s) changed since your last visit to our office? ☐ yes ☐ no

If yes: Address_____

City/State/Zip_____

Phone: Home_____Cell_____Office_____

Please update: Email address_____

Has your dental insurance changed since your last visit to our office? ☐yes ☐no
If yes, please present your new dental insurance card to our receptionist.

Family physician:_____Phone#_____
Address:_____
Additional physician (specialist): _____Office# _____
Address: _____

Please check yes or no to the following questions:
Do you have any current medical problems? ☐ yes ☐ no
If yes, please describe,
_____

Are you currently under the care of a physician? ☐ yes ☐ no Physician name:_____
If yes, please list reason(s):
_____

Have you been hospitalized or had a serious illness within the past 5 years? ☐ yes ☐ no
If yes, please describe,
_____

Have you ever had or been treated for any of the following diseases or medical problems?

☐ yes ☐ no Anemia
☐ yes ☐ no Arthritis
☐ yes ☐ no Glaucoma
☐ yes ☐ no Kidney problems
☐ yes ☐ no Liver Disease/Jaundice
☐ yes ☐ no Rheumatic fever
☐ yes ☐ no Sinus trouble
☐ yes ☐ no Tuberculosis
☐ yes ☐ no Have you had heart trouble or any form of cardiovascular disease?
☐ yes ☐ no Congenital heart lesions
☐ yes ☐ no Atherosclerosis
☐ yes ☐ no Mitral valve prolapse
☐ yes ☐ no Heart murmur
☐ yes ☐ no Heart attack, (date) _____
☐ yes ☐ no Stroke (date), _____
☐ yes ☐ no Heart surgery, (date) _____
☐ yes ☐ no • Pacemaker
☐ yes ☐ no • Bypass
☐ yes ☐ no • Prosthetic valve
☐ yes ☐ no Angina (chest pains), if yes, how often _____
☐ yes ☐ no Emphysema, asthma, breathing problems, briefly explain:_____
☐ yes ☐ no Hypoglycemia/Hyperglycemia (abnormal blood sugar)
☐ yes ☐ no Epilepsy / Seizures, Last episode: _____
☐ yes ☐ no Abnormal bleeding (prolonged)

OVER ⇩

☐ yes ☐ no Diabetes, Type _____ Controlled? Yes/No
☐ yes ☐ no Eating Disorders (anorexia, bulimia)
☐ yes ☐ no AIDS / HIV, Date diagnosed_____
☐ yes ☐ no Chronic Headaches, How often: _____
☐ yes ☐ no Stomach/intestinal ulcers/acid reflux
☐ yes ☐ no Psychiatric problems/nervousness
☐ yes ☐ no Hip/joint replacement
☐ yes ☐ no Cancer/Chemotherapy/Radiation therapy
☐ yes ☐ no High/Low blood pressure, Last BP reading: _____ Date: _____
☐ yes ☐ no **Pregnant**: Month _____
☐ yes ☐ no Are you nursing?
☐ yes ☐ no Have you ever been advised to take preventive antibiotics before dental treatment?
☐ yes ☐ no Have you been treated for any other illnesses not listed above? Explain:_____
_____
☐ yes ☐ no other _____

Are you allergic to any of the following?
☐ yes ☐ no Aspirin
☐ yes ☐ no Penicillin or other antibiotics _____
☐ yes ☐ no Codeine, describe reaction _____
☐ yes ☐ no Barbiturates, sedatives or sleeping pills
☐ yes ☐ no Epinephrine
☐ yes ☐ no Nitrous Oxide
☐ yes ☐ no Sulfa Drugs
☐ yes ☐ no Latex/rubber
☐ yes ☐ no Any metals (ie. nickel, palladium, etc.)
☐ yes ☐ no Local anesthetics like novacaine
☐ yes ☐ no Are you allergic to any other medications? If yes, please explain_____

Please list all medications you are currently taking (prescription, non-prescription, and herbals)

Name	**Purpose**	**Name**	**Purpose**

Do you drink alcohol or use tobacco products or recreational drugs?

☐ yes ☐ no Alcohol (_____) drinks per day

☐ yes ☐ no Tobacco (_____) packs per day for approx (____) years.

☐ yes ☐ no "Recreational drugs" such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor. _____