

MEDICAL HISTORY UPDATE

PATIENT NAME: _____

PHONE NUMBER : HOME _____ CELL _____ WORK _____

ALTERNATE / EMERGENCY CONTACT NAME _____ PHONE NUMBER: _____

CURRENT ADDRESS: _____

E-MAIL ADDRESS: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - PLEASE CIRCLE ALL THAT APPLY TO YOU.

ALLERGIES to latex / drugs / anesthetic list: _____

PREMEDICATE FOR DENTAL PROCEDURES: Yes / No Reason: _____

Heart Attack : year _____

Anemia _____

High Blood Pressure

Excessive bleeding from cuts or extractions

Pacemaker

Covid 19

Heart Valve Replacement / defect type: _____

Hepatitis A or B or C

Arrhythmia

HIV/AIDS

Diabetes

Tuberculosis

Osteoporosis / Osteopenia

Arthritis

Thyroid disease: hypo or hyper

Hip or Joint Replacement of _____ year _____

Asthma

Kidney problem _____

Sinus Problem

Seizure (Epilepsy)

Nasal Septum defect or surgery

Stroke: year _____

Gastric Ulcer / Acid Reflux

Glaucoma

Taking blood thinner for

Anxiety / Depression / Bipolar

Cancer of _____, currently on Chemo or Radiation treatments for _____

Currently Pregnant, if so due date _____

History of Chemical Dependency type _____

-Since last dental visit: * did you have any SURGERIES: _____

*or / and new diagnosed MEDICAL CONDITIONS: _____

List All Current Medication that you are taking including over the counter meds/herbal meds:

SIGNATURE _____ DATE _____

(Parent or guardian if patient is a minor)

Reviewed by _____

form 5/2020