

Patient Medical History - Update

Patient Name _____ Sex: M ___ F ___ Date of Birth ___/___/___ Age ___

Physician/Medical Group _____ Physician Phone # _____

1. Date of last physical exam _____ Routine Illness **PLEASE DESCRIBE ALL YES ANSWERS**
2. Have you been hospitalized in the last 5 years? yes no _____
3. Have you had any surgeries in the last 5 years? yes no _____
4. Are you undergoing any medical treatment? yes no _____
5. Are you presently taking any medication? yes no _____

6. Are you currently or have you ever had Bisphosphonate therapy? yes no _____
7. Have you ever had a reaction to any medication? yes no _____

8. Are you allergic to: Penicillin Local Anesthetic Aspirin Latex _____

9. Do you bleed abnormally after cuts or extractions? yes no _____
10. Have you ever had radiation therapy? yes no _____
11. Have you taken steroids (Cortisone) in the past 2 years? yes no _____
12. Do you smoke or use smokeless tobacco? How much? yes no _____
13. (Women) Are you: Pregnant (Due Date ___/___/___) Take Birth Control Pills _____
14. Are there any other physical, mental, or emotional problems we should be aware of? yes no

If yes, please explain _____

15. Please check if you have ever had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> History of Infective Endocarditis
<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Joint Replacement <input type="checkbox"/> Sickle Cell Disease/Trait
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Tumors
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes I / II	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bone Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Congenital Heart Problems/transplant	<input type="checkbox"/> Infectious Diseases		

Please explain any checked responses _____

- CHILDREN:** still uses baby bottle uses a pacifier sucks thumb/fingers has had orthodontic treatment
- snacks frequently has had poor dental experiences takes a fluoride supplement

Is there anything else we should know about your child? _____

- JAW RELATED PROBLEMS:** difficulty opening/closing mouth injury to jaw/head/neck jaw/joint noises
- pain in or around ears previous treatment for jaw problems or TMJ

(PLEASE SIGN BACK OF FORM)

MEDICAL UPDATES: Please list any changes in health status, medications, hospitalizations, or surgeries:

DATE	CHANGES	PATIENT/GUARDIAN SIGNATURE	DENTIST
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____
__/__/__	_____ none _____	_____	_____