Medical History Update

1. Are you having pain at this time?..Yes/No
2. Have you been a patient in the hospital in the past 2 years ....Yes/No
3. Have you been under the care of a medical doctor in the past 2 years ....Yes/No
   Physicians Name_____________________________Phone Number_________________________
4. Have you taken any medication or drugs in the past 2 years ....Yes/No
   If yes, please list:____
5. Are you now taking medication or drugs...Yes/No
6. Are you sensitive or allergic to any medication, anesthetic or latex......................................Yes/No
7. Indicate which of the following you have had or have at the present time. Circle Yes or No:

AIDS.................................Yes No
Allergies..........................Yes No
Anemia............................Yes No
Angina Pectoris................Yes No
Arteriosclerosis................Yes No
Arthritis............................Yes No
Artificial Heart Valve......Yes No
Artificial Joints................Yes No
Asthma............................Yes No
Blood Transfusion...........Yes No
Cancer.............................Yes No
Chemotherapy................Yes No
Chronic Cough.................Yes No
Cold Sores........................Yes No
Congenital Heart Dis.......Yes No

Cortisone Medication........Yes No
Development. Disabled.....Yes No
Diabetes.............................Yes No
Drug Addiction..................Yes No
Emphysema........................Yes No
Fainting/Dizziness.............Yes No
Glaucoma...........................Yes No
Heart Disease/Attack........Yes No
Heart Murmur...................Yes No
Heart Surgery....................Yes No
Hemophilia.......................Yes No
Hepatitis A.........................Yes No
Hepatitis B (serum)............Yes No
High Blood Pressure..........Yes No
HIV + ...Yes No

Jaundice.............................Yes No
Kidney Problems...............Yes No
Liver Disease.....................Yes No
Mitral Valve Prolapse.......Yes No
Nervousness......................Yes No
Pacemaker.........................Yes No
Radiation Therapy............Yes No
Rheumatic Fever................Yes No
Sickle Cell Disease.............Yes No
Sinus Trouble.....................Yes No
Stroke................................Yes No
Thyroid Problems..............Yes No
Tuberculosis......................Yes No
Tumors..............................Yes No
Ulcers................................Yes No

8. Do you require antibiotic treatment for dental procedures?...Yes No
9. Do you ever have shortness of breath?..Yes No
10. Do your ankles swell during the day?..Yes No
11. Do you use more than two pillows to sleep?...Yes No
12. Have you lost or gained more than 10 pounds in the past year?..Yes No
13. Do you wake up from sleep and feel short of breath?..Yes No
14. Are you on a special diet?..Yes No
15. Do you have or have you ever had any disease, condition or problem NOT listed?............Yes No
    If yes, please list:____
    For women only: Are you pregnant? Yes, what month __________, No______
    Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature____Date_____________