

"Creating healthy, beautiful smiles....for a lifetime."

MEDICAL History Update

YOUR NAME: _____ Today's Date: _____

Physician's Name: _____ Phone #: _____ When was your last visit to your physician? _____

When was your last complete physical? _____

Please tell us if you have had any of the following by checking the appropriate box:

- Bacterial Endocarditis, Heart Murmur, Irregular Heart Beat, High Blood Pressure, Low Blood Pressure, Rheumatic Heart Fever, Rheumatic Heart Disease, Artificial Heart Valves, Congenital Heart Lesion, Mitral Valve Prolapse, Heart Attack, Angina/ Chest Pain, Heart Pacemaker, Heart Surgery, Congestive Heart Failure, Hemophilia, Blood Disease, Sickle Cell Anemia, Anemia / Blood Problems, Excessive Bleeding, Asthma, Respiratory Disease, Shortness of Breath, Hay Fever, Sinus Problems, Tuberculosis, Eye Disorders / Glaucoma, AIDS, Immunosuppressive Disorders / ARC, Any Artificial Replacement, Artificial Knee, Hip, Joint, Pins, Plate, Rheumatism / Arthritis, Neurological Problems, Epilepsy / Seizures, Psychiatric Problems, Emotional Problems, Alcoholism, Chemical Dependency, Drug Addiction, Malignancies, Cancers, Tumors, Growths, Radiation Treatments, Diabetes, Kidney Problems, Dialysis, Liver Problems, Hepatitis, Stroke, Thyroid Problems, Ulcer / Colitis, Venereal Disease, Herpes, Fever Blisters, Pregnant, Oral Contraceptives

Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

Please list all DRUGS/MEDICATIONS that you currently take: _____

Patient Signature

Date