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:

___AIDS/HIV	___ Cancer	___Fainting	___ History of Infective Endocarditis	
___Alcohol Addiction	___ Chemotherapy	___Glaucoma	___ Joint Replacement	___Sickle Cell Disease/Trait
___Anemia	___ Chest Pain	___Hearing Problems	___ Kidney Disease	___Stroke
___Arthritis	___ Cold Sores	___ Heart Disease	___ Learning Disabilities	___Tuberculosis
___Artificial Heart Valve	___ Diabetes	___Heart Surgery	___ Liver Disease	___Tumors
___Asthma	___ Drug Addiction	___ Hepatitis A / B / C	___ Osteoporosis	___Thyroid Disease
___Blood Disease	___ Epilepsy	___Herpes I / II	___ Pacemaker	___Venereal Disease
___Bone Disease	___ Emphysema	___ High Blood Pressure	___ Psychiatric Care	
___Congenital Heart Problems/transplant		___ Infectious Diseases		

Please explain any checked responses____

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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___	____________________________	________