PATIENT MEDICAL HISTORY & UPDATE FORM

Date: _____

Patient Name: _____ DOB: _____

Address: _____City, State, Zip code: _____

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Email: _____

Can we email you or text you to confirm your appointments? YES ____ NO _____

If yes, email only _____ text only _____ both _____

What is the best way to contact you in case of an emergency? _____

Dental Insurance (If different): _____

Pharmacy Name: _____ Phone: (___) _____

Primary Care Physician: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

Do you have, or have you had, any of the following? Please check Yes or No:

❑ Yes ❑ No AIDS/HIV Positive
❑ Yes ❑ No Anaphylaxis
❑ Yes ❑ No Anemia
❑ Yes ❑ No Angina
❑ Yes ❑ No Arthritis/Gout
❑ Yes ❑ No Artificial Heart Valve
❑ Yes ❑ No Artificial Joint
❑ Yes ❑ No Asthma
❑ Yes ❑ No Blood Disease
❑ Yes ❑ No Blood Transfusion
❑ Yes ❑ No Breathing Problem
❑ Yes ❑ No Easily Winded
❑ Yes ❑ No Heart Pacemaker
❑ Yes ❑ No Heart Trouble/Disease
❑ Yes ❑ No Hemophilia
❑ Yes ❑ No Hepatitis A
❑ Yes ❑ No Hepatitis B or C
❑ Yes ❑ No Herpes
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No High Cholesterol
❑ Yes ❑ No Hives or Rash
❑ Yes ❑ No Hypoglycemia
❑ Yes ❑ No Irregular Heartbeat
❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Leukemia
❑ Yes ❑ No Liver Disease
❑ Yes ❑ No Alzheimer's disease
❑ Yes ❑ No Bruise Easily
❑ Yes ❑ No Cancer
❑ Yes ❑ No Chemotherapy
❑ Yes ❑ No Chest Pains
❑ Yes ❑ No Cold Sores/Fever Blisters
❑ Yes ❑ No Congenital Heart Disorder
❑ Yes ❑ No Convulsions
❑ Yes ❑ No Cortisone Medicine
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Drug Addiction
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ No Lung Disease
❑ Yes ❑ No Mitral Valve Prolapsed
❑ Yes ❑ No Osteoporosis
❑ Yes ❑ No Pain in Jaw Joints
❑ Yes ❑ No Parathyroid Disease
❑ Yes ❑ No Psychiatric Care
❑ Yes ❑ No Radiation Treatments
❑ Yes ❑ No Recent Weight Loss
❑ Yes ❑ No Renal Dialysis
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Rheumatism
❑ Yes ❑ No Scarlet Fever
❑ Yes ❑ No Shingles
❑ Yes ❑ No Epilepsy or Seizures
❑ Yes ❑ No Excessive Bleeding
❑ Yes ❑ No Excessive Thirst
❑ Yes ❑ No Fainting Spells/Dizziness
❑ Yes ❑ No Frequent Cough
❑ Yes ❑ No Frequent Diarrhea
❑ Yes ❑ No Frequent Headaches
❑ Yes ❑ No Genital Herpes
❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Hay Fever
❑ Yes ❑ No Heart Attack/Failure
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Sickle Cell Disease
❑ Yes ❑ No Sinus Trouble
❑ Yes ❑ No Spinal Bifida
❑ Yes ❑ No Stomach/intestinal Disease
❑ Yes ❑ No Swelling of Limbs
❑ Yes ❑ No Thyroid Disease
❑ Yes ❑ No Tonsillitis
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Tumors or Growths
❑ Yes ❑ No Ulcers
❑ Yes ❑ No Venereal Disease
❑ Yes ❑ No Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain _____

Patient Signature: _____ Date: _____