**PATIENT INFORMATION**

***MEDICAL UPDATE FORM 2021***

***The information provided is important to your dental health.***

**Email**_____ Date:_____

Patient's name _____ Preferred name _____Birth Date_____Age _____

Home phone _____ Work phone _____If minor, parents names _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

PLEASE LET US KNOW IF YOUR INSURANCE INFORMATION HAS CHANGED

**Emergency Contact**_____**Phone:**_____**Relationship:**_____

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies
- ❑ Asthma
- ❑ Thyroid disease

Do you smoke or use chewing tobacco?__ yes __no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners) __Plavix__Coumadin __Xarelto__Lovenox __Eliquix __Other_____
- ❑ Antibiotics or sulfa drugs
- ❑ Blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Diabetes drug _____
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medications: __Boniva __Fosamax __Zometa __Actonel __Other_____
- ❑ List Medications:_____

_____

_____

Women:

- ❑ May be pregnant/ Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Reason for your visit:_____ Last Dental Exam:_____

Name of your Physician:_____Phone:_____

Do you have any disease, condition, or problem not listed above?_____

Any Major Surgeries, if yes please list type of surgery and date::_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____