Medical History Update

Name: _____ Date of Birth: _____

Please Check All That Apply:

☐ Anemia	☐ Chemical Dependency	☐ Fainting/Dizziness	☐ Hyper-Thyroid	☐ Psychiatric Care
☐ Arthritis	☐ Chemo/Radiation	☐ Glaucoma	☐ Hypo-Thyroid	☐ Sinus Trouble
☐ Artificial Joints	☐ C-Pap Use	☐ Heart Condition	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ Currently Pregnant	☐ Hepatitis	☐ Low Blood Pressure	☐ Tobacco/Vape/Chew
☐ Blood Thinners	☐ Epilepsy	☐HIV	☐ Pacemaker	☐ Tuberculosis
☐ Bone-Building Drugs	☐ No Epinephrine	☐ Jaundice	☐ Pre-medication	☐ Ulcers
☐ Cancer (see below)	☐ Coumadin Use (Last INR)_____		☐ Diabetes (Last A1C) _____	

Any other health conditions? If Yes, Please Explain: _____

_____

Allergies (Not Food or Seasonal): _____

Cancer Patients/Survivors – Type and date: _____

Please List all current Medications: _____

_____

Would you like to change anything about your smile? If Yes, Please Explain: _____

_____

Last Dental Visit: _____ Previous Dentist: _____

Primary Care Physician: _____ Pharmacy: _____

Emergency Contact & Phone Number: _____

Signature: _____ Date: _____