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Annual Medical History Update

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Are you currently under the care of a physician? ◯ Yes ◯ No

If yes, please list provider's name and condition being treated:

_____

_____

_____

Are you taking any prescribed or non-prescribed medications, drugs, or pills? ◯ Yes ◯ No

If yes, please list medications:

_____

_____

_____

Do you require pre-medication prior to dental procedures? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Are you allergic to any of the following:

☐ Latex ☐ Penicillin ☐ Amoxicillin ☐ Aspirin ☐ Tetracycline ☐ Codeine ☐ Local Anesthetics
☐ Acrylic ☐ Metal ☐ Sulfa Drugs ☐ Other

- [ ] *EPI ALERT
- [ ] *Pre-Med
- [ ] Alcohol/Drug Abuse
- [ ] Allergy/Amoxicillin
- [ ] Allergy/Codiene
- [ ] Allergy/Erythromycin
- [ ] Allergy/Latex
- [ ] Allergy/Penicillin
- [ ] Allergy/Sulfa
- [ ] Allergy/Vicodin
- [ ] Alzeheimers Disease
- [ ] Anemia
- [ ] Art Heart Valve
- [ ] Arthritis / Gout
- [ ] Artificial Joints
- [ ] Aspirin
- [ ] Asthma
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Cold Sore/FeverBlist
- [ ] Congenital Heart Def
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting/Dizziness
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] HeartAttack
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV / AIDS
- [ ] Hypoglycemia
- [ ] Kidney Disease
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Mitral Valve Prolasp
- [ ] Neck Pains
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Psychiatric Problems
- [ ] Radiation/Chemo
- [ ] Respiratory Problem
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Severe Headaches
- [ ] Shingles
- [ ] Sinus Problems
- [ ] Stomach Prob/Ulcers
- [ ] Stroke
- [ ] Thrush History
- [ ] Thyroid Disease
- [ ] TMJ/ Jaw Problems
- [ ] Tuberculosis
- [ ] Valley Fever
- [ ] Venereal Disease

Have you ever had any serious illness not listed above?

_____

_____

Please mark any of the following to indicate Yes in response to the question:

- [ ] Have you been hospitalized or had a major operation?
- [ ] Do you use tobacco (smoking or chewing)?
- [ ] Do you require the use of corrective lenses (contacts or glasses)?
- [ ] Have you ever had a serious head or neck injury?
- [ ] Do you take, or have you taken, Phen-Fen or Redux?
- [ ] Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

If any of the previous questions are marked, please explain:

_____

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Do you have any other health issues or allergies?

_____

_____

_____

_____

- [ ] **To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (pr patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

Authorization

Name of patient, parent, or guardian completing this form:

_____

_____

Relationship to Patient:

_____

_____

_____

Response Date: ____/____/_____