



Medical History Update

Print Patient's Name _____

Birth date _____

MEDICAL HISTORY– We ask that you update this form so that your medical history on file remains current.
After completing this form, please sign on the next available signature line.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease/Attack
Heart Murmur
Angina/Chest Pain
Congenital Heart Disorder
Mitral Valve Prolapse
Artificial Heart Valve
Heart Surgery
Heart Pacemaker
Rheumatic Fever
Anemia
Stroke
High/Low Blood Pressure
Blood Transfusion
Excessive Bleeding/Hemophilia
Bruises Easily
Sickle Cell Disease
Hypoglycemia
Diabetes
Liver Trouble

Kidney Trouble
Renal Dialysis
Thyroid Disease
Arthritis/Rheumatism
Pain in Jaw Joint/TMJ Disorder
Tuberculosis
Asthma
Emphysema
Epilepsy/Seizures
Dizziness/Fainting
Cancer
Chemotherapy
Radiation Therapy
Glaucoma
Stomach Problems/Ulcers
Artificial Joint/Prosthesis
AIDS
HIV Positive
Herpes

Venereal Disease
Hepatitis A, B, or C (Circle Type)
Fever Blisters/Cold Sores
Nervousness/Panic Attacks
Psychiatric Care
Alzheimer's Disease
Pregnant/Trying to Get Pregnant
Cortisone Medications
Smoker
Drug Addiction
Sinus Trouble
Codeine Allergy
Penicillin Allergy
List Other Allergies:

Have you ever had another serious illness not listed above? Discuss _____

By my signature below, I acknowledge that all the preceding answers are correct and that I have updated my medical history by making any necessary changes. If I have any changes in my health status, or if my medications change, I will inform the dentist and staff at my next appointment, without fail.

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

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