CENTER FOR DENTAL RESTORATIONS

MEDICAL HISTORY UPDATE

BP:________ **Doctor Initial**:________

Name:_______________________ **Address:**____________________ **Phone:**______________

These questions are for your benefit as your treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concerns, but they are all associated with proper oral health.

Please answer each question. Check Yes or No where applicable.

Any dental concerns? ____

Y N

☐ ☐ Are you in good health?

☐ ☐ Are you now under the care of a physician (PCP and/or Specialist)?

If so, when was your last visit? ____

Any condition(s) being treated? ____

☐ ☐ Any new serious illness, operation, or have been hospitalized?

If yes, please explain what and when ____

☐ ☐ Are you taking any medications?

If so, what and what dosage: ____

____

____

☐ ☐ Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa drugs ☐ Aspirin

☐ Codeine ☐ Other If other, what drugs? ____

☐ ☐ Do you pre-medicate with antibiotics before dental appointments? (i.e. have joint or heart valve replacements)

Do you now have or have you had any of the following: (Please check Yes or No for known conditions.)

Y N		Y N		Y N		Y N		Y N	
☐ ☐	Anemia	☐ ☐	Hemophilia	☐ ☐	Drug Addiction	☐ ☐	Nervous Disorders	☐ ☐	Sickle Cell Disease
☐ ☐	Herpes	☐ ☐	Rheumatism	☐ ☐	kidney disease	☐ ☐	Tumors or Growths	☐ ☐	Tuberculosis (T.B.)
☐ ☐	Stroke	☐ ☐	Heart Murmur	☐ ☐	Stomach Ulcers	☐ ☐	Allergies or Hives	☐ ☐	Epilepsy or Seizures
☐ ☐	Diabetes	☐ ☐	Bruise Easily	☐ ☐	Angina Pectoris	☐ ☐	Cortisone Medicine	☐ ☐	Artificial Joint
☐ ☐	Glaucoma	☐ ☐	Head Injuries	☐ ☐	Mental Disorder	☐ ☐	Excessive Bleeding	☐ ☐	Psychiatric Treatment
☐ ☐	Arthritis	☐ ☐	Heart Failure	☐ ☐	Rheumatic Fever	☐ ☐	Emphysema	☐ ☐	Congenital Heart Lesion
☐ ☐	Asthma	☐ ☐	Liver Disease	☐ ☐	Thyroid Disease	☐ ☐	High Blood Pressure	☐ ☐	Heart Attack
☐ ☐	Hay Fever	☐ ☐	Sinus Trouble	☐ ☐	Cerebral Palsy	☐ ☐	HIV positive	☐ ☐	Hepatitis or Jaundice
☐ ☐	Cold Sores	☐ ☐	Blood Disease	☐ ☐	Fainting spells	☐ ☐	Radiation Treatment	☐ ☐	respiratory disease
☐ ☐	Cancer	☐ ☐	Mitral Valve Prolapse	☐ ☐	Taken Bisphos-phonates(Boniva)	☐ ☐	Osteoporosis/penia	☐ ☐	Latex Allergy
						☐ ☐	AIDS	☐ ☐	Other ______________

☐ ☐ Tobacco Use? If so, what kind and how much? ____

☐ ☐ (Women) Are you pregnant? If so, how many months? ____________________________________

☐ ☐ Do you wear a cardiac pacemaker, or have you had heart surgery? When? _________________

Do you have anything (disease, condition, problem) you would like to add to your medical history not covered above? Please let us know about anything you think we should be aware of:

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To the best of my knowledge, all the preceding information is true and correct. If I have any change in my health or medications, I will inform the provider before my next appointment. I understand that in order to keep accurate records, and to provide the best quality care, updates to my health history and contact information is necessary.

____ ___/____/_______

Signature of Patient or Guardian Date