

*"Creating healthy, beautiful smiles....for a lifetime."*

## MEDICAL History Update

**YOUR NAME:** \_\_\_\_\_ Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ When was your last visit to your physician? \_\_\_\_\_

When was your last complete physical? \_\_\_\_\_

Please tell us if you have had any of the following by checking the appropriate box:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Bacterial Endocarditis   | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Any Artificial Replacement | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Blood Disease            | Artificial Knee, Hip, Joint,                        | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Sickle Cell Anemia       | Pins, Plate   | <input type="checkbox"/> Dialysis              |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Anemia / Blood Problems  | <input type="checkbox"/> Rheumatism / Arthritis     | <input type="checkbox"/> Liver Problems        |
| <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Neurological Problems      | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Rheumatic Heart Fever    | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy / Seizures        | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Rheumatic Heart Disease  | <input type="checkbox"/> Respiratory Disease      | <input type="checkbox"/> Psychiatric Problems       | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Emotional Problems         | <input type="checkbox"/> Ulcer / Colitis       |
| <input type="checkbox"/> Congenital Heart Lesion  | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Chemical Dependency        | <input type="checkbox"/> Herpes                |
| <input type="checkbox"/> Heart Attack _____ year  | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> Fever Blisters        |
| <input type="checkbox"/> Angina/ Chest Pain       | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies               | <input type="checkbox"/> Pregnant _____ months |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Cancers, Tumors, Growths   | <input type="checkbox"/> Oral Contraceptives   |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Immunosuppressive        | <input type="checkbox"/> Radiation Treatments       |  |
| <input type="checkbox"/> Congestive Heart Failure | Disorders / ARC                                   |   |  |

Please list any ALLERGIES to Drugs, Medications or Anesthetics:

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Please list any other MEDICAL CONDITIONS not mentioned above:

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Please list all DRUGS/MEDICATIONS that you currently take:

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date