

MEDICAL HISTORY UPDATE

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (circle the ones that apply):

- Heart Problems/Shortness of breath, Mitral Valve Prolapse, Heart Pacemaker, High Blood Pressure, Low Blood Pressure, Circulatory Problems, Nervous Problems, Radiation Treatment, Chemotherapy, Artificial Heart Valve or Joints, Kidney Problems, Back Problems, Diabetes, Respiratory Disease, Latex Sensitivity, Swollen Neck Glands, Sinus Problems, Stroke, Drug Addiction, Hemophilia, Neurological Disorders, Epilepsy, Headaches, Hepatitis, Jaundice or Liver Disease, Cancer, Psychiatric Care, Chronic Diarrhea, Allergies to Anesthetics, Allergies to Medicine or Drugs, Thyroid Problems, General Allergies, Blood Disease, Arthritis, Contact lenses, Glaucoma, Special Diet, Rheumatic Fever, HIV/AIDS or Other Immunosuppressive Disorders, Ulcer, Venereal Disease, Cold Sores/Fever Blisters, Fainting or Dizzy Spells

Do you use more than two pillows to sleep? _____

Do you use Tobacco? Yes No If yes, how much? _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Do you have problems with snoring or daytime sleepiness or sleep apnea? If yes, circle the ones which apply.

Are you under the care of a physician? Yes No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Date _____ Dr.'s Signature _____

