

Medical History Update

Patient Full Name

Address

Home Phone _____ Business Phone _____

Emergency Phone _____

Closest Relative _____

Relationship _____

1. Have there been any changes in your health since your last dental appointment?

Yes _____ No _____

If yes, for what conditions?

2. Are you taking any medications at this time? Yes _____ NO _____

If yes, please list them

3. Do you have any allergies or adverse reactions to any medications

4. Are you currently pregnant? Yes _____ NO _____

If yes, when is your due date? _____

5. Have you been diagnosed as HIV Positive? Yes _____ No _____

6. Do you have AIDS? Yes _____ No _____

7. Is there anything we need to know about your health that is not listed above? Yes _____

No _____

If yes, please list

8. If there has been no change in your health since your last dental appointment, please check here _____.

NOTE: EVEN IF THERE HAS BEEN NO CHANGE IN YOUR HEALTH HISTORY PLEASE SIGN AND DATE THIS FORM TO BE MADE PART OF YOUR CHART.

Date: _____

Signature:
