

Medical History Update

Last Name: _____ First Name: _____ Birthdate: _____

Emergency Contact _____ Phone _____

Current Medications

New Medications

Current Allergies

New Allergies

DO YOU REQUIRE ANTIBIOTIC PREMEDICATION FOR DENTAL TREATMENT No

Current Medical Conditions

New Medical Conditions

Do you have any health problems that were not listed above? If yes, please explain below:

Are you now under the care of a medical specialist?

Cardiologist: _____ Phone: _____

Orthopedist _____ Phone: _____

Other Specialist _____ Phone: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain: _____

Do you use tobacco? Please explain: _____

WOMEN: Are You Pregnant Trying to get pregnant Nursing Taking Oral Contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or, if my medications change, I will inform the dentist and the staff at the next appointment without fail.

Date: _____

Signature