

OFFICE USE ONLY

Reviewed \_\_\_\_\_ Date \_\_\_\_\_  
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### MEDICAL HISTORY UPDATE

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

- 1) Do you have a family physician?  Yes  No Name \_\_\_\_\_
- 2) Have you been hospitalized in the past 5 years?  Yes  No
- 3) Are you receiving medical treatment now?  Yes  No
- 4) Are you currently taking any drugs or medications?  Yes  No

If yes, please list \_\_\_\_\_

- 5) Have you ever had bleeding problems after a cut or tooth extraction?  Yes  No
- 6) Women: Are you pregnant?  Yes  No Due Date \_\_\_\_\_
- Are you nursing?  Yes  No
- Are you taking birth control pills?  Yes  No

7) Do you have or have you ever had:

Yes No

- Heart attack
- Heart failure
- Angina Pectoris
- Rheumatic Fever
- Heart Murmur
- Mitral Valve Prolapse
- Artificial Heart Valve
- Heart Pacemaker
- High Blood Pressure
- Stroke
- Fainting/Dizziness
- Epilepsy/Seizures
- Asthma
- Emphysema
- Tuberculosis (TB)

Yes No

- Artificial Joints
- Respiratory Disease
- Hepatitis A or B
- Liver Disease
- Blood Transfusion
- Drug/Alcohol Abuse
- Venereal Disease
- A.I.D.S./HIV+
- Intestinal Disease
- Stomach Ulcer
- Diabetes
- Kidney Disease
- Cancer
- Hemophilia
- Thyroid Disease
- Radiation/Chemotherapy

8) Have you ever had an adverse reaction to any of the following: (Check Y or N)

Yes No

- Aspirin
- Darvon
- Novacaine
- Latex

Yes No

- Percodan
- Codeine
- Valium
- Nickel

Yes No

- Erythromycin
- Penicillin
- Nitrous Oxide

Other \_\_\_\_\_

9) Is there any other medical information we should know about? \_\_\_\_\_

Patient Signature (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. A 1.5% PER MONTH FINANCE CHARGE (OR \$3.00 MINIMUM CHARGE FOR ANY BALANCE OF \$200.00 OR LESS) WILL BE ADDED TO ALL OPEN ACCOUNTS AFTER 60 DAYS. AFTER 60 DAYS, ANY OUTSTANDING INSURANCE BALANCES WILL BE TRANSFERRED TO THE PATIENT ACCOUNT.**

**MEDICAL UPDATE**