Medical History Update

Name:	**DOB:**	**Date:**

Physician's Name:	City/State:	Office Phone No:	Date of Last Exam:

List of all Medications:	**List any major changes, surgeries, or problems we should know:**
_____ _____ _____ _____	_____ _____ _____ _____
Have you ever abused narcotics/methamphetamines? Yes No	**Has your physician requested you take a Pre-Med before your dental appointments?** Yes No

Are you allergic to or have you had reactions to: **YES NO**	**Do you have or have you ever had the following:** **YES NO**	**YES NO**	**YES NO**
.....Aspirin	...Allergies (Seasonal)	.....Diabetes	...Mitral Valve Prolapse
.....Codeine	.....Anemia	.....Dizziness	.....Nervousness
.....Erythromycin	.....Arthritis	...Epilepsy/ Seizures	.....Pacemaker
.....Keflex	.....Artificial Joints	...Excessive Bleeding	Respiratory Problems
.....Latex / Rubber	.....Asthma	.....Fainting	.....Rheumatism
...Local Anesthetics	.....Back Problems	.....Glaucoma	.....Scarlet Fever
.....Penicillin	.....Blood Disease	.....Head Injuries	Sexually Transmitted (Disease)
.....Other Antibiotics	..Blood Pressure- High	.....Heart Murmur	.....Sinus Problems
.....Sulfa Drugs	...Blood Pressure- Low	.....Heart Problems	.....Stomach Problems
.....Iodine	.....Blood Thinners	.....Hepatitis	.....Stroke
.....Any Metals	.....Cancer	.....HIV	.....Swelling (Feet, Hands, Etc.)
Other Allergies:	Chemical Dependency	.....Hives/Rash	.....Thyroid Problems
_____	.....Chemotherapy	.....Hypoglycemia	.....Tonsillitis
_____	.....Chest Pain	.....Jaundice	.....Tuberculosis
_____	...Cold Sores/ Blisters	...Joint Replacement	.....Tumors
_____	...Cortisone Treatment	.....Kidney Problems	.....Weight Loss
_____		.....Liver Problems	
_		...Mental Health Care	

Women Only:	Pregnant or think you may be pregnant	Nursing	Taking birth control

Smoketown Family Dentistry

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during this period of such dental care to third party payers and/or health practitioners.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**

Doctor's comments:_____

Signature: Date: