# YEARLY PATIENT MEDICAL HISTORY UPDATE

*PLEASE PRINT THE FOLLOWING INFORMATION*

**Office Use Only**
Date: ________
Doctor : _____
F/O: _____
Assistant : _____
Hygienist: _____

PATIENT NAME____________________________ DATE_____________________

CELL PHONE # ______________________________ DATE OF BIRTH____________

EMAIL__________________________________________________

NAME OF GENERAL DENTIST _________________________ NAME OF PHYSICIAN____________________________

**YES NO**

____ ____ Has dental insurance changed? If so, please notify receptionist.
____ ____ Has home address, work or home phone changed? If so, please list changes on line below.

______________________________________________________________________________

## MEDICAL HISTORY

____ ____ Do you require antibiotic pre-medication for dental treatment?
If "YES" why? ___________________________________________________________

## IN THE PAST HAVE YOU HAD ANY OF THE FOLLOWING:

____ ____ Taken **Blood Thinner** Medication or daily **Aspirin**. If "YES" (circle one)
____ ____ Heart trouble or Stroke: If yes Date: __________________
____ ____ High or Low Blood Pressure (Circle One)
____ ____ Surgery, If "YES" What type ____________________________________________Date __________
____ ____ Drug reaction to: ______________________________________________________________
____ ____ Prosthetic valve (heart) or joint replacement (hip, knee, etc.), or any foreign bodies implanted in your body. If Yes, What?___________________________________________ Date: ___________
____ ____ Diagnosis of a heart murmur or mitral valve prolapse. Date: __________________
____ ____ Diagnosis of Lupus. Date: __________________
____ ____ Diagnosis of Diabetes. Date:__________________
____ ____ If "YES" for how long? Less than 6 months____________
Longer than 6 months __________
____ ____ If you are female, are you now pregnant?
____ ____ If you are female are you currently taking an oral contraceptive?
____ ____ Are you currently taking **ANY** prescription medications? (Please list below). Also have you taken or are you taking medications for osteoporosis? If so List and How long.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_________________________________ _________________________________
Patient's Signature Guardian's Signature if patient is a minor