Update Medical History

Name_____
Date_____
Physician Name_____
Physician Phone Number _____
Date of last visit (approx)_____

Please check **Yes** or **No**

AIDS	Yes ☐	No ☐	Jaw Pain	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Arthritis, Rheumatism	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Artificial Heart Valves	Yes ☐	No ☐	Low Blood Pressure	Yes ☐	No ☐
Artificial Joints	Yes ☐	No ☐	Mitral Valve	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Nervous Problem	Yes ☐	No ☐
Back Problems	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Bleeding Abnormally with extractions	Yes ☐	No ☐	Women:		
			Are You Pregnant?	Yes ☐	No ☐
Blood Disease	Yes ☐	No ☐	Due Date ____/____/_____		
Cancer	Yes ☐	No ☐	Are You Nursing	Yes ☐	No ☐
Chemical Dependency	Yes ☐	No ☐	Psychiatric Care	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Radiation Tx	Yes ☐	No ☐
Circulatory Problems	Yes ☐	No ☐	Respiratory Disease	Yes ☐	No ☐
Congenital Heart Lesion	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Cortisone Treatment	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐
Cough, Persistent or Bloody	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Sinus Problems	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	Skin Rash	Yes ☐	No ☐
Do You Wear Contact?	Yes ☐	No ☐	Smoker	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Special Diet	Yes ☐	No ☐
Fainting/Dizziness	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Swelling: Feet, Neck Glands	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Tonsillitis	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Hepatitis (type ____)	Yes ☐	No ☐	Tumor/Growth on neck or head	Yes ☐	No ☐
Herpes	Yes ☐	No ☐	Ulcer	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐
HIV Positive	Yes ☐	No ☐	Weight Loss	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐			

Current Medications:

_____

_____

_____

_____

Allergies

Aspirin	Yes ☐	No ☐
Penicillin	Yes ☐	No ☐
Codeine	Yes ☐	No ☐