

Today's Date _____

Medical Update

Name _____

Date of Birth _____

Address _____

City, State, Zip _____

Home Phone _____

Cell Phone _____

Place of Employment _____

Work Phone _____

E-mail _____

Family Physician's Name _____

Have you ever been treated by a specialty physician? _____

___ Yes ___ No _____

Please list any hospitalizations in the past five (5) years _____

Please list current medications including prescription drugs, vitamins & dietary supplements _____

Please check all allergies:

___ Y ___ N Latex
 ___ Y ___ N Penicillin
 ___ Y ___ N Erythromycin
 ___ Y ___ N Sulfa
 ___ Y ___ N Foods – Please list _____

___ Y ___ N Aspirin
 ___ Y ___ N Codeine
 ___ Y ___ N Ibuprofen
 ___ Y ___ N Metals
 ___ Y ___ N Other Allergies _____

Please place a check mark if you have had or currently have any of the following diseases or conditions:

___ ADD/ADHD Meds: _____	___ Congenital Heart Defect ___ Diabetes Type: _____	___ Liver Disease ___ Lupus ___ Mental Disorders
___ AIDS/HIV	___ Drug/ Alcohol Abuse	___ Migraines/ Headaches
___ Anemia	___ Emphysema	___ MVP
___ Arthritis	___ Epilepsy/ Seizures	___ Osteoporosis
___ Artificial Joints Type: _____	___ Fainting	___ Pacemaker Placed When: _____
___ Asthma	___ Fibromyalgia	___ Radiation Treatment When: _____
___ Blood Diseases	___ GERD	___ Rheumatoid Arthritis
___ Blood Transfusions	___ Heart Disease	___ Stroke When: _____
___ Cancer Type: _____	___ Heart Murmur	___ Ulcer
___ Chemo Type: _____	___ Hepatitis – A B C Other	___ Venereal Diseases
___ Cold Sores	___ Blood Pressure High ___ Low ___	
	___ HPV	
	___ Kidney Disease	

___ Y ___ N Do you suffer from heavy, frequent snoring?
 ___ Y ___ N Do you currently or have you ever worn a **CPAP** device?
 ___ Y ___ N Would you like us to use our **Velscope Oral Cancer Screening** device for \$53 today?
 ___ Y ___ N Have you ever been told you need an **antibiotic** before a dental appointment?
 Why do you premed? _____

Women: ___ Y ___ N Are you pregnant? ___ Y ___ N Are you nursing?
 Do you use prescription birth control medication? (patch or pill) _____

Please list any other disease or condition you have had that was not mentioned above: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature of patient / parent or guardian

Date