PATIENT UPDATE FORM

Patient Name: **Date:**

Health Information

Have your ever had any of the following? Please check those that apply:

☐ Alzheimer's	☐ Emphysema	☐ Mitral Valve Prolapse
☐ Anemia	☐ Epilepsy/Seizures	☐ Pacemaker
☐ Arthritis	☐ Fever Blisters	☐ Parkinson's Disease
☐ Artificial Bones/Joints	☐ Glaucoma	☐ Psychiatric Problems
☐ Artificial Valves	☐ Heart Attack	☐ Radiation Treatment
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever
☐ Blind	☐ Heart Murmur	☐ Rheumatism
☐ Blood Transfusion	☐ Hemophilia	☐ Severe Headaches
☐ Cancer	☐ Hepatitis	☐ Sinus Problems
☐ Chemotherapy	☐ HIV/Aids	☐ Stomach Problems
☐ Colitis	☐ High Blood Pressure	☐ Stroke
☐ Congenital Heart Defect	☐ Hospitalized Recently	☐ Thyroid
☐ Deaf	☐ Internal Defibrillator	☐ Tuberculosis (TB)
☐ Diabetes	☐ Kidney Problems	☐ Ulcers/Stomach Problems
☐ Drug/Alcohol Abuse	☐ Low Blood Pressure	☐ Venereal Disease

- Do you need to pre-medicate for dental appointments? ☐ Yes ☐ No
- Do you have any health problems not listed above? ☐ Yes ☐ No
  If yes, please explain (use back of page if necessary): _____

_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: (use back of page if necessary): _____

_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  - Name of Physician: _____ Phone: _____

Allergies

Are you allergic to any of the following? If NO, check here: ☐

☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Erythromycin ☐ Ibuprofen
☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Latex

☐ Other (list here): _____

Medications

Are you taking any blood thinners or aspirin? ☐ No ☐ Yes, list here _____

List any medications you are currently taking including any over-the- counter medications, or attach a complete list.

Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date: _____
Signature of patient, parent or guardian

Reviewed By: _____ Date: _____
Signature of employee/doctor