*CALDWELL FAMILY DENTISTRY*

Medical History Update

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of the following:

Y N Heart Conditions

Y N Heart Surgery Date\_\_\_\_\_\_\_\_\_\_

Y N Pacemaker Date\_\_\_\_\_\_\_\_

Y N Valve Replacement Date\_\_\_\_\_\_\_\_\_

Y N Stroke Date\_\_\_\_\_\_\_\_

Y N High Blood Pressure

Y N Bleeding Disorder(s)/anemia

Y N Respiratory Condition(s)/asthma/difficulty breathing

Y N Diabetes, if yes type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Tuberculosis

Y N Kidney/Renal Disease

Y N Hepatitis/Jaundice

Y N HIV Positive

Y N Epilepsy/Seizure Date of last episode \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Joint Replacement Date/Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Liver/Hepatic Disease

Y N Are you currently receiving or have received IV Bisphosphonate Therapy?

Y N Do you currently or have you used tobacco products? If yes, what and how long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Have you used any recreational drugs within the last 24 hrs? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Latex Allergy

Y N Any other allergies (food, medications, dental material) If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Have you experienced local anesthetic complications with dental treatement? If yes, explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please list current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please list any over the counter supplements/medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Do you have any conditions not listed above? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For woman:

Y N Are you pregnant? If yes, expected due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION I HAVE PROVIDED.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE