Dental Medical History Update

Patient Information

Full Name

Date of Birth

Phone

Email

Today's Date

Medical History

Are you under a physicianâ€™s care?

- [ ] Yes
- [ ] No

If yes, please explain

Have you had any hospitalizations or surgeries?

- [ ] Yes
- [ ] No

If yes, please explain

List current medications

Allergies

Do you use tobacco products?

- [ ] Yes
- [ ] No

Women: Are you pregnant?

- [ ] Yes
- [ ] No

If yes, how many months?

Check any of the following that you have had or currently have:

- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Asthma
- [ ] Epilepsy/Seizures
- [ ] Cancer
- [ ] Hepatitis
- [ ] Thyroid Disorder
- [ ] Other

If other, please specify

Dental History Update

Date of Last Dental Visit

Any changes in dental health?

Are you experiencing any dental problems now?

- [ ] Yes
- [ ] No

If yes, please explain

Signature & Verification

Signature

Date