Link Dental | comprehensive restorative dentistry

MEDICAL HISTORY UPDATE

Patient name	Date	Date of birth
Physician's name	Physician's phone:	

List medications presently taken and for what conditions.

Are you now or have you been treated for osteoporosis?

List any medications taken in the last two years.

List herbal supplements.

Do you smoke or chew tobacco?	Have you taken diet medication (Fen-Phen)?	Have you been under a physician's care during the past two years?
Have you ever had any major surgery?		If female: Are you taking hormones or birth control medication?
Have you been treated in a hospital in the past two years?		Are you (or could be) pregnant or nursing?

Have you become sick from or show an allergy to, or been told not to take:

Yes No	Yes No	Yes No
[ ] [ ] Antibiotics (penicillin, etc.)	[ ] [ ] Latex Gloves	[ ] [ ] Other medications (Please List)
[ ] [ ] Sulfa Drugs	[ ] [ ] Metals	
[ ] [ ] Codeine	[ ] [ ] Local anesthetics	
[ ] [ ] Aspirin		

Have you ever had or do you now have:

Yes No	Yes No	Yes No
[ ] [ ] AIDS and/or HIV+	[ ] [ ] Alcohol dependency/addiction	[ ] [ ] Hemophilia/bleeding disorder
[ ] [ ] Artificial heart valves	[ ] [ ] Allergies/hay fever	[ ] [ ] Irregular heartbeat
[ ] [ ] Artificial joints (hips, knees, etc.)	[ ] [ ] Anemia	[ ] [ ] Jaundice
[ ] [ ] Cancer	[ ] [ ] Angina	[ ] [ ] Kidney disease
[ ] [ ] Cardiac pacemaker	[ ] [ ] Arthritis/rheumatism	[ ] [ ] Leukemia
[ ] [ ] Chemotherapy/radiation	[ ] [ ] Asthma	[ ] [ ] Liver disease
[ ] [ ] Congenital heart lesions	[ ] [ ] Bleeding disorder	[ ] [ ] Organ transplant
[ ] [ ] Diabetes	[ ] [ ] Blood pressure (low)	[ ] [ ] Osteoporosis
[ ] [ ] Heart disease	[ ] [ ] Blood pressure (high)	[ ] [ ] Polio
[ ] [ ] Heart murmur	[ ] [ ] Blood trouble/bleed easily	[ ] [ ] Prolonged cough
[ ] [ ] Heart surgery	[ ] [ ] Canker Sores (Recurrent Apthous Ulcers)	[ ] [ ] Psychiatric treatment
[ ] [ ] Hepatitis	[ ] [ ] Drug dependency/addiction	[ ] [ ] Respiratory problems
[ ] [ ] Herpes labialis (cold sores)	[ ] [ ] Emphysema/COPD	[ ] [ ] Sickle cell anemia
[ ] [ ] Mitral valve prolapse	[ ] [ ] Epilepsy/seizures	[ ] [ ] Sexually transmitted diseases
[ ] [ ] Rheumatic fever	[ ] [ ] Eye Disease	[ ] [ ] Sinus trouble
	[ ] [ ] Fainting, convulsions	[ ] [ ] Stroke
	[ ] [ ] Frequent headaches	[ ] [ ] Thyroid disease
	[ ] [ ] Glaucoma	[ ] [ ] Tuberculosis
	[ ] [ ] Heart attack (when?) _____	[ ] [ ] Ulcers

Do you have any disease, condition, or problem not previously listed?

Signature

Office Use Only

Date:	Date:	Date:	Date:	Date:	Date: