

Updated Medical History

Please print

Name _____ Date of Birth _____

Email address _____

Have you ever had or presently have any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ/Jaw Joint Pain |
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Avocados <input type="checkbox"/> Kiwi | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Banana <input type="checkbox"/> Chestnuts | <input type="checkbox"/> Fainting | Due date: _____ | <input type="checkbox"/> Needs PRE-MED |
| <input type="checkbox"/> Other Allergies: | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Spina Bifida |
| Please | <input type="checkbox"/> Heart - MVP | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other _____ |
| list: _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | _____ |
| _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Skin Rashes/Hives | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoker | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | _____ |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |

• Are you presently taking any drugs or medications? Yes No

If yes, please List: _____

Please list all surgeries in the last five years: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

Signature of patient, parent or guardian

Date: _____

Printed name