MEDICAL HISTORY UPDATE

Patient Name : _____ **Date:** _____

Physician's Name_____ Address_____ Phone _____

Please list all medications you are currently taking or using prescription and OTC. _____

_____

Are you currently under a Physicians care? *Y N* **Please list any serious medical condition(s) that you have experienced. _____ Do you need pre-medication for any procedures** *Y N*
Do you or have you experienced any of the following? (Please circle Y/N)

Abnormal Bleeding **Y N**	Anemia **Y N**	Fever Blisters **Y N**	Cancer **Y N**
Colitis **Y N**	Diabetes **Y N**	Herpes **Y N**	Headaches **Y N**
Heart Murmur **Y N**	Hemophilia **Y N**	Seizures **Y N**	HIV+/AIDS **Y N**
Liver Disease **Y N**	Pacemaker **Y N**	Asthma **Y N**	Tuberculosis (TB) **Y N**
Alcohol Use **Y N**	Artificial Joints **Y N**	Glaucoma **Y N**	Chemotherapy **Y N**
Congenital Heart Defect **Y N**	Emphysema **Y N**	High Blood Pressure **Y N**	Heart Attack **Y N**
	Hepatitis **Y N**	Tobacco	Kidney Problems **Y N**
Heart Surgery **Y N**	Radiation Treatment **Y N**	Smoke/chew**YN**	Venereal Disease **Y N**
Lupus **Y N**	Artificial Valves **Y N**		

Women: Are you taking birth control pills? Y N Are you pregnant? Y N Week #: _____ Are you nursing? ___

Are you allergic to any of the following?
Latex *Y N* - Ibuprofen *Y N* – Codeine Y *N*- Barbiturates *Y N* - Jewelry/Metals *Y N* - Sulfa Drugs *Y N*
Aspirin *Y N* -Tetracycline *Y N* - Dental Anesthetics *Y N* - Penicillin *Y N*
Are you allergic to anything not listed if so what? _____

Is Pre- Medication needed prior to your dental visit Yes or No?

Have you ever tested positive for COVID 19? If so when? _____
Since then have you tested negative? If so when? _____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Onsite Dental of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

***SIGN*_____*DATE*_____**