Bailey, & Ge - Family Dentistry

Medical History Update

Patient Name ______________________________ Address ______________________________

Home Phone ____________________ Work Phone ________________ Cell Phone ____________________

General Physician __________________ Office Phone: ______________________________

Any medical changes since your last visit to us: ______________________________

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1. Are you under medical treatment now? Yes No

2. Have you been hospitalized for any surgical operation or serious illness since your last visit here? Yes No

3. Are you taking any medication(s) including non-prescription medicine? Yes No
   Please list: ______________________________
   ____
   ____
   ____
   ____

4. Have you ever been advised to take an antibiotic prior to dental treatment? Yes No
   Why? ______________________________

5. Do you smoke? Yes No

6. Are you allergic to or have you had reactions to the following:

Latex	Yes	No
Local Anesthetics (eg. Novocain)	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Erythromycin	Yes	No
Codeine	Yes	No
Metals	Yes	No
Aspirin	Yes	No
Other		

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7. Women only!
   a) Are you pregnant or think you may be? Yes No
   b) Are you nursing? Yes No
   c) Are you taking birth control pills? Yes No

8. Do you have or have you had any of the following?

Artificial/Replacement Joint	Yes	No
Artificial Valves	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Cardiac Pacemaker	Yes	No
Heart Murmur/Mitral Valve Prolapse	Yes	No
Rheumatic Fever	Yes	No
Heart Disease/Heart Attack	Yes	No
Chest Pains/Angina	Yes	No
Are you taking Coumadin?	Yes	No
Stroke	Yes	No
Epilepsy/Convulsions	Yes	No
Fainting	Yes	No
Respiratory Problems	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Hay Fever/Seasonal Allergies	Yes	No
Asthma	Yes	No
Hepatitis/Jaundice	Yes	No
Liver Disease	Yes	No
Anemia	Yes	No
Kidney Disease	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Stomach troubles/Ulcers	Yes	No
Bleeding disorders	Yes	No
Cancer/Leukemia	Yes	No
Radiation Therapy	Yes	No
Frequent Headache	Yes	No
Arthritis	Yes	No
Joint Replacement or Implant	Yes	No
AIDS/HIV infection	Yes	No

Other ______________________________

Change in Dental Insurance ______________________________

New ID # ______________________________ Effective Date: ____________________

Patient Signature: ______________________________ Date ____________________

Address changes please inform the front desk