

Update Medical History

Name and Date _____

Physician Name, phone number & Date of last visit (approx.) _____

Please circle Yes or No

	Yes	No		Yes	No
AIDS	Y	N	Jaw Pain	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Arthritis, Rheumatism	Y	N	Liver Disease	Y	N
Artificial Heart Valves	Y	N	Low Blood Pres.	Y	N
Artificial Joints	Y	N	Mitral Valve	Y	N
Asthma	Y	N	Nervous Problem	Y	N
Back Problems	Y	N	Pacemaker	Y	N
Bleeding abnormally			Women :		
with extractions	Y	N	Are you pregnant	Y	N
Blood Disease	Y	N	Due Date _____		
Cancer	Y	N	Are you nursing?	Y	N
Chemical Dependency	Y	N	Psychiatric care	Y	N
Chemotherapy	Y	N	Radiation Tx.	Y	N
Circulatory problems	Y	N	Respiratory Dise	Y	N
Congenital Heart Lesion	Y	N	Rheumatic Fever	Y	N
Cortisone Treatment	Y	N	Scarlet Fever	Y	N
Cough, Persistent or			Shortness of		
bloody	Y	N	breath	Y	N
Diabetes	Y	N	Sinus Problems	Y	N
Emphysema	Y	N	Skin Rash	Y	N
Do You Wear Contacts	Y	N	Special Diet	Y	N
Epilepsy	Y	N	Stroke	Y	N
Fainting/Dizziness	Y	N	Swelling ; Feet	Y	N
Glaucoma	Y	N	neck glands	Y	N
Headaches	Y	N	Thyroid problems	Y	N
Heart Murmur	Y	N	Tonsillitis	Y	N
Heart Problems	Y	N	Tuberculosis	Y	N
Hepatitis (type)	Y	N	Tumor/Growth on		
Herpes	Y	N	neck or head	Y	N
High Blood Bressure	Y	N	Ulcer	Y	N
HIV positive	Y	N	Venereal Disease	Y	N
Jaundice	Y	N	Weight Loss	Y	N
Smoker	Y	N	ALLERGIES		
CURRENT MEDICATIONS:			Aspirin	Y	N
			Penicillin	Y	N
			Codeine	Y	N