B&G Dental **Medical History Update**

Patient ____
Last Name First Name Middle Initial Nickname

Address ____

Cell # ________________ Home # ________________ E-mail ________________________________

Name of physician: ______________________ Phone # ________________ Date of last visit: ___/___/____

Have you ever been hospitalized? If yes, please explain ____

Y	N	
☐	☐	Cardiovascular Disease Congenital Heart Disease, Heart Disease, Heart Attack, Angina
☐	☐	Rheumatic Fever
☐	☐	Heart Murmur Mitral Valve Prolapse, Damaged Valves
☐	☐	High or Low Blood Pressure
☐	☐	Blood Disorders Hemophilia, Anemia / Wafarin, Coumadin
☐	☐	Artificial Joint, Heart Valve
☐	☐	Cardiac Pacemaker
☐	☐	Metal Rods, Pins, Implants
☐	☐	Hepatitis A B C
☐	☐	AIDS/HIV
☐	☐	Stroke
☐	☐	Epilepsy/Seizures
☐	☐	Cognitive or Intellectual Impairments ADD/ADHD, Autism, etc
☐	☐	Pre-medicate prior to dental treatment (currently, or history of)

Y	N	
☐	☐	Drug/Alcohol Abuse
☐	☐	Tobacco Use
☐	☐	Sexually Transmitted Disease
☐	☐	Thyroid Problems
☐	☐	Ulcers
☐	☐	Glaucoma
☐	☐	Sinus Trouble
☐	☐	Limited Mobility or Dexterity Arthritis, Back Pain, Multiple Sclerosis, etc
☐	☐	Asthma
☐	☐	Problems with Mental Health
☐	☐	Lung Disease
☐	☐	Tuberculosis
☐	☐	Cancer/Tumor Chemotherapy, Radiation
☐	☐	Diabetes Patient, Family History
☐	☐	History of Bisphosphonate Medications Osteoporosis, Chemotherapy

ALLERGIES/REACTIONS

Y	N		Y	N	
☐	☐	Codeine/Narcotics	☐	☐	Tetracycline
☐	☐	Aspirin	☐	☐	Anesthetics
☐	☐	Penicillin	☐	☐	Latex
☐	☐	Erythromycin	☐	☐	Metals
☐	☐	Sulfa	☐	☐	Environmental

Other____

CHECK ALL THAT APPLY

Y	N	
☐	☐	Contraceptives?
☐	☐	Hormones?
☐	☐	Menopause?
☐	☐	Are you nursing?
☐	☐	Are you pregnant?

If so, how far along?____________

MEDICATIONS

Please list any prescription or over the counter medications you are taking at this time.

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

Do you have any disease, condition or problem not listed above that you think we should know about? If yes, please explain.

____

I UNDERSTAND that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature____**Date**__________________
(If under 18, Parent or Guardian signature required.)