CONFIDENTIAL

MEDICAL HISTORY UPDATE

PLEASE PRINT DATE: _____

Patient Name: _____

Address: _____ City: _____ St: ___ Zip: _____

Home Number: _____ Work: _____ Cell: _____

Email: _____

How would you like to be contacted? ☐ Email ☐ Cell ☐ Home ☐ Work

Has the patient ever been told she/he has had:

Yes	No	1. An allergic reaction to any drugs?
Yes	No	If YES, list: _____
Yes	No	2. A reaction to an anesthetic injection?
Yes	No	3. Sinus Problems?
Yes	No	4. Rheumatic fever, Heart Murmur, Mitral valve prolapse?
Yes	No	5. Pace maker, Stroke?
Yes	No	6. High blood pressure?
Yes	No	7. Diabetes?
Yes	No	8. Hepatitis, Kidney, or Liver Disease?
Yes	No	9. Venereal Disease?
Yes	No	10. Excessive or prolonged bleeding?
Yes	No	11. Tested HIV Positive?
Yes	No	12. Nervous or mental condition?
Yes	No	13. If female, are you pregnant?
Yes	No	14. Do you smoke or use smokeless tobacco?
Yes	No	15. Hip or knee replacement?
Yes	No	If YES, date: _____
Yes	No	16. Any recent medications?
Yes	No	17. Any additional information we should know about your health?

_____

_____ _____

Patient Signature

Parental Permission
(if patient is under 21)