

UPDATED MEDICAL HISTORY FORM

Name: _____ Date: _____

Have you or a family member ever been treated for a skin condition or skin cancer since your last visit? yes no (person, type, location, year, treatment) _____

List surgeries/hospitalizations including year and reason, that have occurred since your last visit:

Have you been diagnosed or treated for any of the following since your last visit?

<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>Yes</u>	<u>No</u>
Angina or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Rhythm Disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Do you take antibiotics before you go to the Dentist? yes no (if yes, why?) _____

Do you take blood thinners yes no (please list) _____

Provide information on any condition for which you responded "yes" to above: _____

Have you developed any new allergies to medication, food, or anesthetic (numbing medicine)?

yes no _____

List all medications that you are currently taking. Include over-the-counter medications and medications that you take only occasionally:

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>

Is there any other information that the physician should be aware of? _____

Patient Signature: _____ Date: _____

Read and reviewed with the patient. _____ Date: _____

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