# PATIENT UPDATE FORM

**Patient Name:** **Date:**

## Health Information

**Have your ever had any of the following? Please check those that apply:**

| | | |
|---|---|---|
| ☐ Alzheimer's | ☐ Emphysema | ☐ Mitral Valve Prolapse |
| ☐ Anemia | ☐ Epilepsy/Seizures | ☐ Pacemaker |
| ☐ Arthritis | ☐ Fever Blisters | ☐ Parkinson's Disease |
| ☐ Artificial Bones/Joints | ☐ Glaucoma | ☐ Psychiatric Problems |
| ☐ Artificial Valves | ☐ Heart Attack | ☐ Radiation Treatment |
| ☐ Asthma | ☐ Heart Disease | ☐ Rheumatic Fever |
| ☐ Blind | ☐ Heart Murmur | ☐ Rheumatism |
| ☐ Blood Transfusion | ☐ Hemophilia | ☐ Severe Headaches |
| ☐ Cancer | ☐ Hepatitis | ☐ Sinus Problems |
| ☐ Chemotherapy | ☐ HIV/Aids | ☐ Stomach Problems |
| ☐ Colitis | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Congenital Heart Defect | ☐ Hospitalized Recently | ☐ Thyroid |
| ☐ Deaf | ☐ Internal Defibrillator | ☐ Tuberculosis (TB) |
| ☐ Diabetes | ☐ Kidney Problems | ☐ Ulcers/Stomach Problems |
| ☐ Drug/Alcohol Abuse | ☐ Low Blood Pressure | ☐ Venereal Disease |

- Do you need to pre-medicate for dental appointments? ☐ Yes ☐ No
- Do you have any health problems not listed above? ☐ Yes ☐ No
  If yes, please explain (use back of page if necessary): _____

_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: (use back of page if necessary): _____

_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  - Name of Physician: _____ Phone: _____

## Allergies

**Are you allergic to any of the following? If NO, check here:** ☐

☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Erythromycin ☐ Ibuprofen
☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Latex

☐ Other (list here): _____

## Medications

**Are you taking any blood thinners or aspirin?** ☐ No ☐ Yes, list here _____

List any medications you are currently taking including any over-the- counter medications, or attach a complete list.

Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date: _____
Signature of patient, parent or guardian

Reviewed By: _____ Date: _____
Signature of employee/doctor