Medical History Update

Last Name:______________ First Name: ______________ Birthdate: ______________

Today Date: ______________ Address:

Physician Name: ______________

Pharmacy Name:______________

Email:

Physician Phone: ______________

Marital Status:

Pharmacy Phone:

Phone:

Medications

List current medications and line through discontinued medications

Do you have any of the following medical conditions?

Y	N	Condition
☐	☐	Abnormal Bleeding
☐	☐	Acid Reflux
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artifical Joint- Hip,Knee
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing/COPD
☐	☐	Do You Have City Water?
☐	☐	Emphysema
☐	☐	Endocarditis-Now Or Previous
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Grinding Or Clenching Teeth

Y	N	Condition
☐	☐	HIV/AIDS
☐	☐	Healing Complications
☐	☐	Heart Attack
☐	☐	Heart Bypass Or Stent
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis. Type:__________
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Pace Maker
☐	☐	Periodontal (Gum) Treatment
☐	☐	Psychiatric Treatment
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	MS
☐	☐	Sleep Apnea/Snoring
☐	☐	STD

If Female Please Answer The Following...

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

Are you allergic to any of the following?

Y	N	
☐	☐	Anesthetic
☐	☐	Metals
☐	☐	Codeine
☐	☐	Penicillin

Y	N	
☐	☐	Latex
☐	☐	Other

Signature:__________________________ Date: _____________________