MEDICAL HISTORY UPDATE

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Patient Medical History Primary Care Physician_____

HAVE YOU EVER HAD, OR BEEN TOLD THAT YOU HAVE, ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
___	___	Heart Disease	___	___	Anemia	___	___	Thyroid Disease
___	___	Heart Murmur	___	___	Liver Disease	___	___	High Blood Pressure
___	___	Heart Attack	___	___	Hepatitis	___	___	Low Blood Pressure
___	___	Chest Pain (Angina)	___	___	Bleed Easily	___	___	Stroke
___	___	Congenital Heart Defect	___	___	Jaundice	___	___	Stomach Ulcer/Problems
___	___	Rheumatic Fever	___	___	HIV/AIDS	___	___	Radiation Therapy
___	___	Mitral Valve Prolapse	___	___	Sexually Transmitted Disease	___	___	Cancer
___	___	Asthma	___	___	Kidney Disease	___	___	Recent Weight Loss
___	___	Shortness of Breath	___	___	Swelling of Hands & Feet	___	___	Psychiatric Treatment
___	___	Respiratory Problems	___	___	Fainting Spells/ Dizziness	___	___	Sinusitis
___	___	Diabetes	___	___	Convulsions	___	___	Arthritis
___	___	Glaucoma	___	___	Epilepsy	___	___	Allergies? To What? ____
___	___	Joint Replacement or Implant	___	___	Other _____			
___	___	Tuberculosis						

YES NO

___ ___ Have you ever had any serious illness other than above?
Please explain_____

___ ___ Are you under the care of a physician at the present time?
Why?_____

Please list all medications that you are currently taking:

_____ _____
_____ _____
_____ _____

___ ___ Have you ever had a bad reaction to local anesthetic or penicillin?
Please explain_____

___ ___ Have you ever had a bad reaction to any other drug?
Please explain_____

___ ___ Have you ever had any operations? What?_____
_____ When?_____

___ ___ Female: Are you now pregnant? What month?_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE CONFIDENTIAL INFORMATION IS TRUE.

SIGNATURE_____ **DATE**_____