Updated Medical History

Date: _____

Patient: _____

Medical History

Are you in good health at the present time? _____
Are you under the care of a Physician? _____
Are you taking any medications? Please list _____
Do you have any allergies? Please list _____

Do you have or have had any of the following:

Diabetes _____ Heart Disease _____ High/Low Blood Pressure _____ Asthma _____
HIV _____ Tuberculosis _____ Thyroid Disorder _____ Epilepsy _____ Cancer _____
Arthritis _____ Digestive Disorder _____ Sexually Transmitted Disease _____
Stroke _____ Kidney Disease _____ Hepatitis _____ Hearing Loss _____ Earaches ____
Frequent Headaches _____ Other _____

Do you Bruise easily or Bleed abnormally? _____
Have you Gained or Lost weight recently? _____If yes, how much? _____
Do you have Frequent Neck, Shoulder or Back pain? _____
Ringing in ears? _____ Do you smoke? _____
Have you ever had any major injury or surgery to the face or Jaw? _____
Do you grind your teeth? _____
Any pain/numbness in the head, neck or jaws? _____
Do you frequently have indigestion? _____
Are you Pregnant? _____

Has your phone number or address changed since your last visit? _____
_____
_____
_____

I the undersigned, hereby certify that all of the medical and dental information provided to be true to the best of my knowledge and that I have not knowingly omitted any information.

Signature: _____