



[Your Address Here]

[Your office # Here] 972/949-5208 (pager) 972/404-1911 (home) www.robertsdds.com

Medical History Update Form

Name Last First Middle Dentist's Name
Social Security # Ht Wt Date of Birth

If you are completing this form for another person, what is your relationship to that person?

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

- 1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical examination was on
4. Are you now under the care of a physician? Yes No
5. The name and address of your physician is:
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
7. Are you taking any medicine(s), including non-prescription medicine(s)? Yes No
8. Do you have or have you had any of the following diseases or problems?
9. Hepatitis, jaundice, or liver disease. Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you been treated for a tumor? Yes No
12. Are you allergic or have you had a reaction to:
13. Are you pregnant? Yes No
14. Do you have any menstrual problems? Yes No
15. Are you nursing? Yes No
16. Are you taking birth control pills? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Dr. Roberts Signature of Patient (or Patient's Guardian)

** RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY **