



[Your Address Here]

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

Medical History Update Form

Name _____ Date _____
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.

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|--|---|
| 1. Are you in good health?..... Yes No | h. Hepatitis, jaundice, or liver disease..... Yes No |
| 2. Has there been any change in your general health within the past year? Yes No | i. AIDS or HIV infection..... Yes No |
| 3. My last physical examination was on _____ | j. Thyroid problems..... Yes No |
| 4. Are you now under the care of a physician? Yes No | k. Respiratory problems, bronchitis, etc. Yes No |
| If so, for what condition? _____ | l. Stomach ulcer or hyperacidity Yes No |
| 5. The name and address of your physician is: | m. Kidney trouble Yes No |
| _____ | n. High or Low blood pressure..... Yes No |
| _____ | o. Sexually transmitted disease Yes No |
| _____ | p. Epilepsy/other neurological disease? Yes No |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No | q. Problems with the spleen Yes No |
| 7. Are you taking any medicine(s), including non-prescription medicine(s)? Yes No | 9. Have you had abnormal bleeding? Yes No |
| If so, what medicine(s) are you taking? _____ | Or required a blood transfusion? Yes No |
| _____ | 10. Do you have any blood disorder such as anemia? Yes No |
| 8. Do you have or have you had any of the following diseases or problems? | 11. Have you been treated for a tumor? Yes No |
| a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease Yes No | 12. Are you allergic or have you had a reaction to: |
| b. Cardiovascular disease, angina, heart attack, heart trouble, stroke Yes No | a. Local anesthetics Yes No |
| c. Allergy Yes No | b. Penicillin or other antibiotics Yes No |
| d. Sinus trouble..... Yes No | c. Sulfa drugs Yes No |
| e. Asthma or hay fever Yes No | d. Barbiturates, sedatives, sleeping pills Yes No |
| f. Fainting spells or seizures Yes No | e. Aspirin Yes No |
| g. Diabetes..... Yes No | f. Iodine Yes No |
| | g. Codeine or other narcotics Yes No |
| | h. Other _____ |

Women

- | |
|--|
| 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. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

Signature of Dr. Roberts

Signature of Patient (or Patient's Guardian)

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