MEDICAL HISTORY UPDATE

PATIENT NAME____HOME PHONE_____________________

MAILING ADDRESS____CELL PHONE______________________

CITY ___________________________ST________ZIP____________WORK PHONE_____________________

Has there been any change in your health since your last dental appointment? ☐ YES ☐ NO

For what conditions? ____

Have you had any **surgery or knee /hip replacements**? ____YES ____NO

If so, what/when? ____

Are you taking any **medications / supplements OR injections** at this time? ☐ YES ☐ NO

If so, what? ____

Do you have **Osteoporosis**? ____YES ____NO

Do you have any allergies (or adverse reactions) to any medications/anesthetics? ☐ YES ☐ NO

If so, what? ____

Are you allergic to Latex or do you have any other allergies? ☐ YES ☐ NO

If so, what? ____

Patient/Guardian Signature ____

Date_________________________