

# 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: \_\_\_\_\_