Medical History Update Form

Mr. Miss. Mrs. Ms. Dr.

Name: _____ Home: _____

Date of Birth: _____ Cell: _____

Home Address: _____ Email: _____
City: _____ Postal Code: _____

Emergency Contact: _____
Phone: _____

Pharmacy: _____ Address: _____
Tel: _____ Fax*: _____

Tell us about your health

Certain medications and medical conditions can affect your oral health, making it important to have your up-to-date medical information provided to your dentist and hygienist. This is critical information especially when considering oral surgery.

1. Are you taking any medications, non-prescription drugs, or herbal supplement of any kind? If yes, please list.

Medications:	Reason Prescribed:
A)	
B)	
C)	
D)	
E)	
F)	

2. Please **check** all that apply:

☐ High blood pressure
☐ High cholesterol
☐ Chest pain
☐ Heart murmur
☐ Shortness of breath
☐ Heart attack *date:* _____
☐ Angina
☐ Pacemaker
☐ Cardiac transplant
☐ Mitral valve prolapse
☐ History of endocarditis
☐ Prosthetic cardiac valve /repair / stent
☐ Bleeding disorder
☐ Bleeding problem
☐ Cancer: _____*year:* ____
☐ Leukemia
☐ Radiotherapy
☐ Chemotherapy
☐ Steroid therapy
☐ Thyroid disease
☐ Osteoporosis
☐ Acid reflux
☐ GERD (Gastroesophageal Reflux Disease)
☐ Stomach ulcer
☐ IBS ☐Ulcerative Colitis ☐Crohn's
☐ Lung disease ☐ COPD ☐ Cystic Fibrosis
☐ Seizures (Epilepsy)
☐ Parkinson's
☐ Memory issue ☐ Dementia ☐ Alzheimer's
☐ Fibromyalgia
☐ Kidney disease
☐ Stroke ☐ TIA
☐ Organ transplant: _____
☐ Joint Replacement☐Hip☐Knee☐Shoulder
☐ Surgery: _____
☐ Cleft Lip ☐ Cleft Palate
☐ Liver disease
☐ Jaundice
☐ Arthritis
☐ Asthma
☐ ADD ☐ ADHD
☐ Autism
☐ Anxiety
☐ Depression
☐ Diabetes Type ☐ 1 or ☐ 2
☐ Headaches ☐ Migraines
☐ Vertigo
☐ Gout
☐ Sleep Apnea/use CPAP machine
☐ Hepatitis ☐ A or ☐ B or ☐ C
☐ HIV ☐ AIDS
☐ Rheumatic fever
☐ Tuberculosis
☐ Use cannabis
☐ Smoke ☐chew tobacco products
☐ Drug and alcohol dependency
☐ Pregnant ☐ Breastfeeding

3. Do you have any allergies/sensitivities? If yes, please list (ex: Penicillin, Amoxicillin, Codeine, Sulfa Drugs, Epinephrine etc.)
   Medications: _____
   Latex/Rubber products: _____
   Other (ex. Hay fever, foods): _____

4. Is there anything else we should be aware of?
   _____
   _____

I,_____consent and understand that in some cases, Dr. Malette/Morin/Beaudry may need to contact my medical doctor for additional information. To the best of my knowledge, the above information is correct.

_____

Patient/Parent/Guardian Signature: Date: (mm/dd/yyyy)