MARKET SQUARE DENTAL

MEDICAL HISTORY UPDATE

NAME: _____DOB: _____

ADDRESS: _____

EMAIL: _____

PHONE#: _____

1. Has there been any changes in your health, such as serious illnesses, hospitalizations or new allergies? Yes No Not Sure
2. Are you taking any new medications or has there been any changes in your medications? If so, explain. Yes No Not Sure
3. Have you had a new heart problem diagnosed or had any changes in an existing heart problem?
4. When was your last medical check up? _____
5. Were any problems identified? If yes, please explain. Yes No Not Sure
6. Have you had an orthopedic joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications? Yes No
7. Are you taking any medications for osteoporosis (Fosomax, Actenol, Atelvia, Bonivia, Reclast,Prolia) Yes No
8. Has a physician of previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No
9. **Women Only:** Are you pregnant? Yes/No Nursing? Yes/No Are you using birth control? Yes/No
10. Additional information and/ or changes to your health, not listed above.

Reviewed by
Doctor/Staff:_____

Signature of Patient/Legal Guardian: _____Date: