

Date:

Occupation:

Patient's Name:

Employer:



306 West 20th Street
Houston, Texas 77008

Referred by:

Phone: 713-862-6408 Fax: 713-862-2187

UPDATED MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please list below.
Have you ever been hospitalized/had a major operation?
Have you ever had a serious head or neck injury?
Have you had a joint replacement? If so, please list which joint and when.
Have you had any heart surgeries including but not limited to stents, heart valve replacement or bypass grafts?
Are you taking any medications, pills or drugs?
Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco or vaping products?
Do you use any controlled substances?
Women: Are you Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?
Are you allergic to any of the following? Aspirin Penicillin Codeine Latex
Other: I do not have any allergies. Metal Sulfa drugs Acrylic Local anesthetics
Clindamycin Food or Sodium Lauryl Sulfate (SLS) allergy:

Systemic Health History: please select if you had/have any of the following:

Cardiovascular: Endocarditis, Angina, Artificial heart valve, Congenital heart disorder, Irregular heartbeat, Heart attack/failure, Heart murmur, Heart pacemaker, Heart disease, Mitral valve prolapse
Endocrine: Excessive thirst, Diabetes, Hypoglycemia, Thyroid disease, Osteoporosis, Parathyroid disease
Eyes/ENT/Respiratory: Asthma/wheezing, Chest pain/tightness, Frequent cough, Sleep apnea, Chronic obstructive pulmonary disorder (COPD), Glaucoma, Tonsillitis, Emphysema, Tuberculosis
Hematology/Hepatology: Anemia, Bruise/bleed easily, Hemophilia, Sickle cell anemia, Hepatitis A, B or C, High blood pressure, Low blood pressure, Stroke
Genitourinary: Frequent diarrhea, Renal dialysis, Ulcerative colitis, Kidney problems
Muscular/Skeletal/Skin: Spina bifida, Swelling of limbs, Hives/rash, Pain in jaw joints, Dry mouth, Herpes/venereal disease
Psychiatric/Neurological: Alzheimer's disease, Anxiety/depression, Psychiatric care, Seizures/convulsions, Tardive dyskinesia, Fainting spells/dizziness, Parkinson's disease
Other illnesses: Shingles, Scarlet fever, Ulcers, Hay fever, Alcohol use disorder, Drug use disorder, Recent weight loss, Use of semaglutide/ozempic
Have you ever had any serious illness not listed above? Yes No If yes
I do not have/have not had any of the illnesses listed above.

Contact information

Current mailing address
Current phone number
Current email address
Emergency contact and number

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

Date: