Burlison Dentistry

MEDICAL HISTORY UPDATE FORM

Print Form

Today's Date: _____

First Name: _____ Last Name: _____ MI: _____

I prefer to be called: _____ Birth Date: ____/____/_____ S&H: _____

Home Address: _____ City: _____ State:_____ Zip: ____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#_____ Cell#: _____ Work#: _____ Email: _____

PRIMARY INSURANCE

Insurance Co: _____ Insured's Name: _____

Insured's DOB: _____ ID# _____ Group*: _____

Have you ever had any of the following diseases or medical problems?

☐	Abnormal Bleeding	☐	Glaucoma	☐	Mitral Valve Prolapse
☐	Alcohol/Drug Abuse	☐	Hay fever	☐	Osteoporosis/Paget's
☐	Anemia	☐	Heart Attack	☐	Pacemaker
☐	Arthritis	☐	Heart Murmur	☐	Psychiatric Care
☐	Artificial Bones/Joints/Valves	☐	Heart Surgery	☐	Radiation Treatment
☐	Asthma	☐	Hemophilia	☐	Rheumatic/Scarlet Fever
☐	Blood Transfusion	☐	Hepatitis	☐	Seizures
☐	Cancer/Chemotherapy	☐	Herpes/Fever Blisters	☐	Shingles
☐	Colitis	☐	High Blood Pressure	☐	Sickle Cell Disease/Traits
☐	Congenital Heart Defect	☐	HIV/AIDS	☐	Sinus Problems
☐	Diabetes	☐	Hospitalize for any reason	☐	Stroke
☐	Difficulty Breathing	☐	Kidney Problems	☐	Thyroid Problems
☐	Emphysema	☐	Liver Disease	☐	Tuberculosis
☐	Fainting Spells	☐	Low Blood Pressure	☐	Ulcers
☐	Frequent Headaches	☐	Lupus	☐	Veneral Disease
Are you Allergic to any of the followings:					
☐	Aspirin	☐	Erythromycin	☐	Tetracycline
☐	Codeine	☐	Latex	☐	Other
☐	Dental Anesthetics	☐	Penicillin		

Please lit any other drugs/ materials that you are allergic to: _____

Are you pregnant? ☐ **YES** ☐ **NO**

Do you smoke or use tobacco in any other form? ☐ **YES** ☐ **NO**

Have you had any metal rods, pins implants? ☐ **YES** ☐ **NO**

Are you taking any prescription/ aver-the-counter or herbal supplemental drugs? ☐ **YES** ☐ **NO**

Please list each one: _____

Signature: _____ Reviewed by clinical staff: _____

Submit Form