PROSTHODONTICS of TEXAS

**MEDICAL HISTORY UPDATE**

*Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for updating your medical history.*

**Patient Information:**

- Full Name: _____ Date of Birth: _____
- Address: _____
- City: _____ State: _____ Zip Code: _____
- Phone Number: _____ Email Address: _____
- Emergency Contact Name: _____ Contact Phone: _____

**Medical History:**

1. **Since the last time we saw you, have you been diagnosed with any of the following conditions?**
   (Please check all that apply)

| | |
|---|---|
| ☐ Heart disease or heart problems | ☐ High blood pressure |
| ☐ Stroke | ☐ Diabetes (Type 1 or Type 2) |
| ☐ Asthma or breathing problems | ☐ Cancer: _____ |
| ☐ Hepatitis or liver disease | ☐ Kidney disease or dialysis |
| ☐ Thyroid disease | ☐ Seizures or epilepsy |
| ☐ Autoimmune diseases | ☐ Anxiety, depression, or mental health |
| ☐ Blood disorders | ☐ Tuberculosis or lung disease |
| ☐ HIV or AIDS | ☐ Other: _____ |

2. **Do you take any new medications?**
   (Please list all new prescribed, over-the-counter, and herbal supplements)
   - _____
   - _____

3. **Have you had any surgeries or hospitalizations since the last time we saw you?**
    - ☐ Yes ☐ No
      If yes, please describe: _____

4. **Are you allergic to any of the following?**
   (Please check all that apply)

| | |
|---|---|
| ☐ Penicillin | ☐ Aspirin or other pain medications |
| ☐ Latex | ☐ Novocain or other local anesthetics |
| ☐ Sulfa drugs | ☐ Other: _____ |

5. **Do you now have any of the following?**
   (Please check all that apply)

| | |
|---|---|
| ☐ Artificial heart valve | ☐ Joint replacement or implants |
| ☐ Organ transplant | ☐ Blood thinners or anticoagulants |
| ☐ Pacemaker or defibrillator | ☐ Endocarditis or heart valve issues |
| ☐ Pregnancy or planning to become pregnant | ☐ Bleeding problems |
| ☐ Alcohol or drug dependency | ☐ Smoking/ use of tobacco products |
| ☐ Other: _____ | |

6. **Do you have any of the following lifestyle factors?**
   (Please check all that apply)

| | |
|---|---|
| ☐ Smoker | ☐ Alcohol use |
| ☐ Recreational drug use | ☐ High-stress levels |
| ☐ Limited physical activity | |

- **Signature of Patient/Guardian:** _____
- **Date:** _____