3550 S. 4800 W.
(801) 969-3025

Patient Name _____
Today's date ___/___/____

MEDICAL HISTORY UPDATE

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving the box blank will indicate a "NO" response.

☐ *Pre-med- Amox ☐ *Pre-med- Clynd ☐ *Pre-med- Other
☐ Aids/HIV

☐ Allergies ☐Allergy- Aspirin ☐ Allergy- Codeine ☐Allergy- Erythro ☐Allergy- Hay Fever ☐Allergy- Sulfa
☐ Allergy- Latex ☐Allergy- Other ☐Allergy- Penicillin
☐Allergy- Tetracycline

☐Anemia ☐ Arthritis ☐ Artificial joints
☐ Asthma ☐ Back problems ☐ Abnormal bleeding
☐ Blood disease ☐ Cancer ☐ Chemotherapy

☐ Circulatory problems ☐Congenital heart disease ☐ Cortisone treatments
☐Cough, persistent ☐ Diabetes ☐ Dizziness/ Fainting
☐ Emphysema ☐ Epilepsy ☐ Glaucoma
☐ Headaches ☐ Heart murmur

☐ Hepatitis ☐ Herpes ☐ High blood pressure
☐ Jaundice ☐ Kidney disease ☐ Liver disease
☐ Mental disorders ☐ Mitral Valve Prolaps ☐ Nervous disorders

☐ Pacemakers ☐ Pregnancy ☐ Psychiatric care
☐ Radiation treatment ☐ Respiratory problems ☐ Rheumatic fever
☐ Rheumatism ☐ Scarlet fever ☐ Shortness of breath

☐ Sinus problems ☐ Skin rash ☐ Stomach problems
☐ Stroke ☐ Thyroid ☐ Tuberculosis
☐ Tumors ☐ Ulcers ☐ Venereal disease

☐ Ever been hospitalized (illness or injury)
☐ Presently being treated for illness
☐ Subject to frequent headaches

☐ Tobacco/Alcohol use

☐ FEMALE: Taking birth control pills

☐ FEMALE: Pregnant

(don't forget the back side!)

→Any other conditions or alerts that need further clarification, please describe:

→Do you take antibiotic premedication for your dental visits? If yes, please explain.

→What is your estimate of your overall general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

→Name of your primary care physician and phone number:

→Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment:

→Are you taking any medication (prescription and non-prescription) including regular doses of Aspirin? If yes, please list below.

☐ Yes ☐ No

→Medications:

☐ By checking this box, I acknowledge that I have reviewed all questions and alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Date ___/___/_____