SUMMERLIN DENTAL
SOLUTIONS

MEDICAL HISTORY UPDATE

Name: _____ Date: _____

Please list any: Prescriptions, Over the Counter Medications or Herbal/ Vitamins:

_____

_____

Are you currently under the care of a doctor? Y/N

Have you had surgery or been hospitalized since last visit? Y/N

If Yes, explain: _____

Are you currently being treated for or have a history of the following?

Heart problems such as:		Hip/Joint Replacement or Pins	Y/N
(attack, pacemaker, surgery)	Y/N	Pacemaker/ Shunts/ Artificial Valve	Y/N
High Blood Pressure	Y/N	Chronic Cough> 3 weeks	Y/N
Hepatitis Type _____	Y/N	Bloody Mucus/ Spit	Y/N
Heart Murmur	Y/N	Unexplained Weight Loss	Y/N
Mitral Valve Prolapse	Y/N	Night Sweats	Y/N
Rheumatic Fever	Y/N	Taking Blood Thinners	Y/N
Diabetes	Y/N	Been Exposed to Tuberculosis	Y/N
Stroke	Y/N	Osteoporosis	Y/N

If you circled yes to any please indicate date below:

_____

_____

Have you ever had any allergic reactions to any of the following?

Codine	Y/N
Penicillian	Y/N
Aspirin	Y/N
Latex	Y/N
Other _____	

List Any Changes Below:

Address: _____

Home#: _____ Cell#: _____

Email: _____ Dental Insurance: _____

_____ _____

(Signature of Patient or Patient's Guardian) **(Signature of Treating Doctor)**