

MEDICAL HISTORY UPDATE

MID-VALLEY DENTAL ASSOCIATES
Brian Tidwell, DDS



Name: _____

Physicians Name: _____ Date of last physical: _____

Have you had any serious illness or operations? yes ___ no ___ If yes, describe: _____

For female patients only:

Are you pregnant? yes ___ no ___ Nursing? yes ___ no ___ Taking birth control pills? yes ___ no ___

Do you require antibiotics prior to dental treatment? yes ___ no ___

Please check if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Alzheimers, Dementia, memory loss | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Shortness or breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other (describe): | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Ulcers |
| | | | <input type="checkbox"/> Venereal disease |

MEDICATIONS: _____

ALLERGIES: _____

Are there any changes to your contact or insurance information? yes ___ no ___ *If yes, please fill out the sections below.*

CONTACT INFORMATION:

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____

INSURANCE INFORMATION:

Primary insurance carrier: _____ Subscriber ID No: _____ Group No: _____

Secondary insurance carrier: _____ Subscriber ID No: _____ Group No: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____ Phone: _____

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge.

Signature of patient (or of parent or guardian if patient is a minor)

Date