

Medical History Update

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Phone: _____

Please help us keep your records current by answering the questions below.

Medical History

When was your last complete physical exam? _____ Reason: _____

Physician's Name: _____ Phone: _____

Have you been hospitalized in the last 5 years? _____ Reason: _____

Are you currently taking any medication? _____

Please list: _____

Have you ever taken Fosamax or any other osteoporosis medications? _____ If yes, what? _____

Are you allergic to or have you had any adverse reaction to any medication? _____

Are you allergic to penicillin or other drugs? _____ Are you allergic to anesthetic or latex? _____

Do you have, have you ever been treated for, or have you ever been told you might have:

YES NO

- ☐ ☐ Artificial Joint
- ☐ ☐ Heart Valve Implant
- ☐ ☐ Heart Disease
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Murmur
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ High Blood Pressure

YES NO

- ☐ ☐ Low Blood Pressure
- ☐ ☐ Stroke
- ☐ ☐ Radiation Treatment
- ☐ ☐ Cancer
- ☐ ☐ Asthma
- ☐ ☐ Hives
- ☐ ☐ Diabetes

YES NO

- ☐ ☐ Kidney Disease
- ☐ ☐ Jaundice
- ☐ ☐ Herpes 1
- ☐ ☐ Herpes 2
- ☐ ☐ Epilepsy
- ☐ ☐ Arthritis
- ☐ ☐ Tuberculosis

YES NO

- ☐ ☐ Anemia
- ☐ ☐ Respiratory Disease
- ☐ ☐ Fainting Spells
- ☐ ☐ HIV
- ☐ ☐ Menopause
- ☐ ☐ Hepatitis Type: _____
- When: _____

Are you pregnant? _____ Do you smoke? _____ Do you consume alcoholic beverages? _____

Have you ever bled excessively after being cut or wounded? _____

Have you ever tested positive for HIV? _____

Have you ever had any other serious medical problem? _____

Explain: _____

Is there anything else we should know about your health? _____

Patient Authorization and Signature

I have read and answered the above questions to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient _____

Date _____

Office Use Only

Date	Update	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____