Triangle Family Dentistry
State-of-the-Art Comfort Dentistry

Patient Medical History Update

Patient Name:_____ **Date:**_____

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care.

Please answer the following questions IF there has been a change in your information.

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Gender: ☐ Male ☐ Female

1. Have you ever been seriously ill since your last office visit? ☐ Yes ☐ No
2. Have there been any changes in your medical history since your last office visits?

If yes, please explain: _____

_____

3. Is a medical doctor currently treating you? ☐ Yes ☐ No
If yes, please explain: _____

_____

4. Please provide your primary care physician's name and phone number:

_____

5. Please list any medications you are taking, prescription or over-the-counter:

_____

6. Are you allergic to, or have you had unusual reactions to any of the following?

Please check all that apply:

☐ Penicillin	☐ Codeine	☐ Sulfa Drugs
☐ Aspirin	☐ Latex	☐ Barbiturates
☐ Iodine	☐ Erythromycin	☐ No Known Allergies

7. Please check the box if you have ever had or been told you have any of the following:

Heart Defect	☐	AIDS	☐
Infective Endocarditis	☐	Rheumatic Fever	☐
High Blood Pressure	☐	Hepatitis	☐
Low Blood Pressure	☐	Tuberculosis	☐
Diabetes	☐	Stroke	☐
Heart Attack	☐	Jaundice	☐
Herpes	☐	Frequent Headaches	☐
Hives/Skin Rash	☐	Asthma	☐
Epilepsy	☐	Hay Fever	☐

7 cont'd – Please check the box if you have ever had or been told you have any of the following:

Seizures	☐		
Anemia	☐	Venereal Disease	☐
Depression	☐	Kidney Disease	☐
Deviated Septum	☐	Active Infection	☐
Arthritis	☐	Swollen Neck Glands	☐
Pacemaker	☐	Osteoporosis	☐
Sinus Trouble	☐	Thyroid Problems	☐

Other ☐ Please explain: _____

8. Have you ever taken a bisphosphonate such as Fosamax, Actonel or Boniva? ☐ Yes ☐ No

QUALITY OF SLEEP:

9. Have you been told you snore occasionally? ☐ Yes ☐ No
10. Do you wish you slept better and had more energy? ☐ Yes ☐ No
11. Have you been prescribed or do you use a CPAP? ☐ Yes ☐ No
12. Do you feel tired throughout the day? ☐ Yes ☐ No

FOR WOMEN ONLY:

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics because antibiotics can cause failure of birth control pills, which can result in pregnancy.

13. Are you pregnant or suspect that you may be pregnant? ☐ Yes ☐ No
14. Are you taking oral contraceptives (birth control pills)? ☐ Yes ☐ No
15. If you use other types of birth control medications that are not pills (such as Depo shots), please list:

_____

_____

16. My current dental goals are (please check all that apply):

☐ Whiter Teeth	☐ Full Dentures	☐ Better Chewing
☐ Pain Free	☐ Cavity Free	☐ Sedation Dentistry
☐ Straighter Teeth	☐ Better Breath	☐ Stop Snoring
☐ Healthier Gums	☐ Less Bleeding	
☐ Replace Missing	☐ Decrease Sensitivity	
☐ Teeth	☐ Partials	

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. I consent to the diagnostic procedures and dentistry necessary for proper dental care.

Signature X _____