John R. Carson, DDS, PC

Patient Name ____________________ Date ________

Street ________ Apt# ________ City ________ State ________ Zip ________

Home Phone# ________ Cell Phone# ________ Work Phone# ________ E-Mail ________

MEDICAL HISTORY UPDATE

Are you under a physician's care now? ☐Yes ☐No Who? ____________________ Phone ________
Why? ____________________

Have you ever been hospitalized or had a major operation in the past year? ☐Yes ☐No
Discuss ____________________

Have you ever had a serious injury to your head or neck? ☐Yes ☐No
Discuss ____________________

Are you taking any medications, pills or drugs? ☐Yes ☐No
What? ____________________

Are you allergic to any medications or substances? Please check box below
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex Rubber ☐Other ____________________

Women (Please check): ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking oral contraceptives

Do you now have or have you ever had any of the following? Please circle the appropriate answer.

Heart Trouble/Disease	Y	N	Bruise Easily	Y	N	Emphysema	Y	N	Yellow Jaundice	Y	N	Cold Sores	Y	N
Heart Murmur*	Y	N	Anemia	Y	N	Tuberculosis	Y	N	Kidney Problems	Y	N	Fever Blisters	Y	N
Irregular Heart Beat	Y	N	Excessive Bleeding	Y	N	Cancer	Y	N	Renal Dialysis	Y	N	Herpes	Y	N
Angina/Chest Pain	Y	N	Sickle Cell Disease	Y	N	X-Ray Treatments (Radiation)	Y	N	Thyroid Disease	Y	N	Stroke	Y	N
Heart Attack/Failure	Y	N	Hemophilia (Bleeding Problem)	Y	N	Chemotherapy	Y	N	Parathyroid Disease	Y	N	Convulsions	Y	N
Congenital Heart Disorder	Y	N	Leukemia	Y	N	Stomach/Intestinal Disease	Y	N	Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N
Mitral Valve Prolapse*	Y	N	Recent Blood Transfusion	Y	N	Ulcers	Y	N	Rheumatism	Y	N	Fainting or dizziness	Y	N
Scarlet Fever	Y	N	Swelling of Limbs	Y	N	Recent Weight Loss	Y	N	Pain in Jaw Joints	Y	N	Glaucoma	Y	N
Rheumatic Fever*	Y	N	Lung Disease	Y	N	Frequent Diarrhea	Y	N	Cortisone Medicine	Y	N	Tumors or Growths	Y	N
Artificial Heart Valve*	Y	N	Breathing Problem	Y	N	Diabetes	Y	N	Artificial Joint*	Y	N	Nervousness	Y	N
Heart Pace Maker*	Y	N	Shortness of Breath	Y	N	Excessive Thirst	Y	N	Venereal Disease	Y	N	Psychiatric Care	Y	N
Heart Surgery	Y	N	Frequent Cough	Y	N	Hypoglycemia	Y	N	HIV Positive	Y	N	Alzheimer's Disease	Y	N
High Blood Pressure	Y	N	Hay Fever	Y	N	Liver Disease	Y	N	Genital Herpes	Y	N	Allergies (pollen/ dust	Y	N
Low Blood Pressure	Y	N	Sinus Trouble	Y	N	Hepatitis A (Infectious)	Y	N	Drug Addiction/ Alcoholism	Y	N	Hives or Rash	Y	N
Blood Disease	Y	N	Asthma	Y	N	Hepatitis B or C	Y	N	Tattoos	Y	N	Need Premedication	Y	N
Unexplained Fever	Y	N	Bloody Sputum	Y	N	Night Sweats	Y	N	AIDS	Y	N	Tobacco Use	Y	N

Have you ever had any other serious illness not circled above? Discuss ____________________ ☐Yes ☐No
Do you wish to talk to the dentist privately about any problem? ____________________ ☐Yes ☐No
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ____________________ Date ________
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ____________________ Date ________
Notes