MEDICAL HISTORY UPDATE

Patient Name: _____ Date of Birth: _____

Phone: Home _____ Cell: _____ Work: _____

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

Email: _____

May we contact you by text: ☐ YES ☐ NO May we contact you by email: ☐ YES ☐ NO

Family Status: Married _____ Single _____ Other _____

Employer: _____ Occupation: _____

Emergency contact:

Name _____ Relationship _____ Phone_____

WITHIN THE PAST YEAR HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH: ☐ YES ☐ NO

If yes, please explain: _____

Primary Care Physician: _____ Phone: _____

WOMEN ONLY: Are you pregnant: ☐ YES ☐ NO ☐ DO NOT KNOW If yes, due date: _____

HAS A PHYSICIAN RECOMMENDED YOU TAKE ANTIBIOTIC PREMED PRIOR TO DENTAL TREATMENT?

☐ YES ☐ NO If yes, for what condition: _____

Antibiotic name and dosage: _____

Prescribing physician Name/Phone: _____

DO HAVE ANY OF THE FOLLOWING CONDITIONS:

YES	NO		YES	NO	
☐	☐	Artificial heart valve	☐	☐	Congenital heart disease (CHD)
☐	☐	Previous infective endocarditis	☐	☐	Unrepaired, cyanotic CHD
☐	☐	Damaged valves in transplanted heart	☐	☐	Repaired CHD completely in last 6 months
			☐	☐	Repaired CHD with residual defects

☐ ☐ Joint replacement (which joint): _____ Date placed: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Amoxicillin	☐	☐	Aspirin	☐	☐	Cipro	☐	☐	Clindamycin	☐	☐	Codeine
☐	☐	Erythromycin	☐	☐	Keflex	☐	☐	Latex	☐	☐	Metals	☐	☐	Mycin's
☐	☐	Penicillin	☐	☐	Sedatives	☐	☐	Sulfa	☐	☐	Dental Injection Reaction			
☐	☐	Topical Local Anesthetics				☐	☐	Other Medications						

PLEASE MARK YES IF YOU HAVE, OR NO IF YOU HAVE NOT HAD, ANY OF THE FOLLOWING CONDITIONS:

YES	NO		YES	NO		YES	NO	
☐	☐	Cardiovascular Disease	☐	☐	Angina	☐	☐	Arteriosclerosis
☐	☐	Congestive Heart Failure	☐	☐	Damaged Heart Valve	☐	☐	Heart Attack
☐	☐	Heart Murmur	☐	☐	Low Blood Pressure	☐	☐	High Blood Pressure
☐	☐	Other Congenital Heart Defects	☐	☐	Mitral Valve Prolapse	☐	☐	Pacemaker
☐	☐	Rheumatic Fever	☐	☐	Rheumatic Heart Disease	☐	☐	Abnormal Bleeding
☐	☐	Anemia	☐	☐	Blood Transfusion (date)_____	☐	☐	Hemophilia
☐	☐	AIDS/HIV	☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Rheumatoid Arthritis	☐	☐	Autoimmune Disease	☐	☐	Bronchitis
☐	☐	Systemic Lupus Erythematosus	☐	☐	Emphysema	☐	☐	Sinus Trouble
☐	☐	Tuberculosis	☐	☐	Cancer	☐	☐	Chemo/Radiation
☐	☐	Chest pain upon exertion	☐	☐	Chronic Pain	☐	☐	Diabetes I or II _____
☐	☐	Eating Disorder	☐	☐	Malnutrition	☐	☐	Ulcers
☐	☐	Gastrointestinal Disease	☐	☐	GE Reflux/Persistent heartburn	☐	☐	Thyroid Problem
☐	☐	Stroke	☐	☐	Glaucoma	☐	☐	Hepatitis/Jaundice
☐	☐	Liver Disease	☐	☐	Epilepsy	☐	☐	Fainting/Seizures
☐	☐	Kidney Problem	☐	☐	Night Sweats	☐	☐	Osteoporosis
☐	☐	Persistent Swollen Neck Glands	☐	☐	Severe Headache/Migraine	☐	☐	Sexually Transmitted Disease
☐	☐	Excessive Urination	☐	☐	Severe/ Rapid Weight Loss	☐	☐	Neurological Disorder (specify)
☐	☐	Recurrent Infection (type) _____						_____
☐	☐	Mental Health Disorder (specify)_____						

PLEASE LIST ANY OTHER DISEASE, CONDITION, OR PROBLEM WHICH IS NOT LISTED ABOVE:

_____

DO YOU TAKE ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS: ☐ **YES** ☐ **NO**

PLEASE LIST ALL MEDICATIONS:

_____

_____

_____

_____

	YES	NO
Do you snore or have you been told that you snore	☐	☐
Have you ever had a sleep study or been told to have a sleep study	☐	☐
Have you ever been diagnosed with sleep apnea	☐	☐
Do you wear a C-PAP or have you been told to wear one	☐	☐

If you have had a sleep study or been diagnosed with sleep apnea, please provide the following information:

Date of Study _____

Medical Facility and Provider of the study _____

I ACKNOWLEDGE THAT I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT PROVIDING INCORRECT OR INACCURATE INFORMATION MAY BE DETRIMENTAL TO MY HEALTH.

PRINT: PATIENT/PARENT/ GUARANTOR NAME_____

SIGNATURE: PATIENT/PARENT/GUARANTOR _____

HIPAA Authorization to release protected information.
Please Print

I, (patient name) _____ authorize the following person(s) to have access to my personal information covered under the HIPAA Privacy Act. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

NAME RELATIONSHIP

1)_____

2)_____

3)_____

4)_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at Walton Dental Care, 862 Michael Etchison Rd., Monroe, GA 30655

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Patient Signature _____ Date _____