



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 | <input type="checkbox"/> | | |
| Anemia | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Deviated Septum | <input type="checkbox"/> | Active Infection | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Swollen Neck Glands | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |
| Sinus Trouble | <input type="checkbox"/> | Thyroid Problems | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | 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):

- | | | |
|---|---|---|
| <input type="checkbox"/> Whiter Teeth | <input type="checkbox"/> Full Dentures | <input type="checkbox"/> Better Chewing |
| <input type="checkbox"/> Pain Free | <input type="checkbox"/> Cavity Free | <input type="checkbox"/> Sedation Dentistry |
| <input type="checkbox"/> Straighter Teeth | <input type="checkbox"/> Better Breath | <input type="checkbox"/> Stop Snoring |
| <input type="checkbox"/> Healthier Gums | <input type="checkbox"/> Less Bleeding | |
| <input type="checkbox"/> Replace Missing | <input type="checkbox"/> Decrease Sensitivity | |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> 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 _____