Gandy Dental

Medical History Update

Patient Name _____ D.O.B. _____

1. Physician_____ Address_____

2. When was your last physical examination? _____

3. Are you under the care of a physician? ..... □Yes □No
   If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? ..... □Yes □No
   If yes, please list: _____

5. (Women) Is there a chance you are pregnant? ..... □Yes □No
   If yes, anticipated due date? _____

6. Are you allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex
   □Pine Nuts □Dyes □Other: _____

7. Do you have Diabetes? ..... □Yes □No
   If yes, please indicate: □Type 1 □Type 2 Last HbA1c date and level: _____

8. Do you have, or have you ever had:

Abnormal blood pressure..... □Yes □No
Anemia ..... □Yes □No
Arthritis ..... □Yes □No
Artificial heart valve/stent/graft..... □Yes □No
Artificial joint replacements ..... □Yes □No
Asthma ..... □Yes □No
Cancer ..... □Yes □No
Chemical dependency..... □Yes □No
Chemotherapy/radiation ..... □Yes □No
Congenital heart defects ..... □Yes □No
Corticosteroid treatment ..... □Yes □No
Epilepsy/seizure ..... □Yes □No
Excessive or prolonged bleeding ..... □Yes □No
Fainting spells ..... □Yes □No
Glaucoma ..... □Yes □No
Hearing impaired ..... □Yes □No
Heart murmur ..... □Yes □No
Heartpacemaker ..... □Yes □No
Heart surgery ..... □Yes □No
Heart trouble ..... □Yes □No
Hepatitis (Type __) ..... □Yes □No
HIV positive/AIDS ..... □Yes □No
Jaundice ..... □Yes □No
Kidney trouble/Dialysis ..... □Yes □No
Leukemia ..... □Yes □No
Oral herpetic lesions ..... □Yes □No
Osteoporosis/treatment/Bisphosphonates □Yes □No
Psychiatric care..... □Yes □No
Rheumatic fever ..... □Yes □No
Sexually transmitted disease ..... □Yes □No
Sinus trouble ..... □Yes □No
Stroke ..... □Yes □No
Thyroid problem ..... □Yes □No
Tuberculosis or Lung Disease ..... □Yes □No
Ulcers/GERD ..... □Yes □No

9. Do you take pre-medication for anything? ..... ☐Yes ☐No
   If you pre-medicate, what for? _____

10. Have you had any other serious illness, hospitalization or accident? ..... ☐Yes ☐No
    If yes, please explain: _____

Patient Signature _____ **Date** _____

(Parent/Guardian)