Time 9:17 AM | Dr. Christopher B Benton | Date 1/4/2022

UPDATED MEDICAL HISTORY

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you have any heart conditions or disorders?	Yes No	If yes
Do you require a premedication prior to dental procedures?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A, B, or C	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Renal Dialysis	Yes No	Anemia	Yes No	Easily Winded	Yes No	Emphysema/COPD	Yes No
High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No
Shingles	Yes No	Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Sinus/breathing Trouble	Yes No	Blood Disease	Yes No
Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No	Blood Transfusion	Yes No
Stomach/Intestinal Disease	Yes No	Frequent Headaches	Yes No	Liver Disease/Jaundice	Yes No	Stroke	Yes No
Low Blood Pressure	Yes No	Cancer	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Chest Pains	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Heart Pacemaker	Yes No
Ulcers	Yes No	Heart Disease/ Disorder	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____