Germantown Dental & Cosmetic Center
19512 Amaranth Drive
Germantown, MD 20874
Patient Medical History Update

Patient Name: _____ Date: _____

Have there been any changes in your address, phone number or insurance coverage since your last appointment? If yes, please list: New Address _____

New Phone Number: Cell: ( ) Home: ( ) Work: ( ) .

New Insurance Name: _____ Group #: _____

MAY WE CONFIRM YOUR APPOINTMENTS BY EMAIL? Yes Email Address:_____

Date of last health care exam:_____ What was done for?_____

Have you been hospitalized in the last 5 years? (Please circle) Yes No

If yes, reason: _____

Are you currently receiving care? Yes No If yes, nature of care: _____

Please List all names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

K Yes K No Are you under any Medical Treatment now?
K Yes k No Have you had any major operations? If so, what? _____
K Yes k No Have you ever had a serious accident involving head or jaw injuries?
K Yes k No Have you had any adverse response to any drugs including penicillin and aspirin?
K Yes k No Have you ever had any of the following?

K Heart Ailment	k Any Blood Disease	K Abnormal or Previous Bacterial Endocarditis
K High Blood Pressure	k Any Liver Disease	K Heart Valve (artificial) or Heart Transplant
K Low Blood Pressure	k Any Kidney Disease	K Congenital Heart Disease
K Respiratory Disease	k Any Stomach or Intestinal Disease	K Heart Disease, Heart Attack, Heart Surgery
K Diabetes	k Any Venereal Disease	K Heart Stent? When placeed?
K Rheumatic Fever	k Yellow Jaundice or Hepatitis	
K Rheumatism or Arthritis	k Epilepsy	
K Tumors or Growth	k AIDS	

K Yes k No Are you on a diet at this time?
K Yes k No Are you now taking drugs or medications?
K Yes k No Are you allergic to any known materials resulting in – hives, eczema, etc?
K Yes k No Do you have any reason to suspect you are not in good health?
K Yes k No Have any wounds healed slowly or presented other complications?
K Yes k No WOMEN – Are you pregnant? Due Date? _____
K Yes k No Do you have a history of fainting?
K Yes k No Have you ever had any X-RAY TREATMENTS (other than diagnostic)?
K Yes k No Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
K Yes k No Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
K Yes k No Have you ever taken Fen-Phen/Redux?
K Yes k No Do you have a history of Tuberculosis?

Are you allergic or have you had a reaction to:

Local anesthetic	K Yes k No	Penicillin or other antibiotics	K Yes k No
Aspirin, Ibuprofen or Tylenol	K Yes k No	Codeine. Valium or other sedatives	K Yes k No
Latex or metal	K Yes k No	Other (please specify)_____	

Please list of any medications you are currently taking and dosages:

1._____ 4._____
2._____ 5._____
3._____ 6._____

I certify that the information given are correct to the best of my knowledge:
Signature: _____ Date: _____