

Shierling Family Dentistry	Patient Information Update
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Patients Name: _____ DOB: _____
 Address _____ City _____ State _____ Zip _____
 Home# _____ Cell _____ Work _____
 Email _____ In case of Emergency Contact: _____
 Preferred Pharmacy: _____ Phone# _____

Medical Health History

Do you or have you had any of the following?

- Cancer or tumor
- Heart Complications
- Rheumatic fever
- Artificial joint or valve
- High blood Pressure
- Low blood Pressure
- Pacemaker
- Tuberculosis
- Lung disease
- Kidney disease
- Hepatitis
- Liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurological condition
- Epilepsy, seizures, or fainting spells
- Psychological condition
- Aids or HIV Positive
- Herpes/cold sores
- Migraine or frequent headaches
- Anemia or blood disorders
- Blood clotting disorders
- Hay fever or sinus problems
- Allergies or hives
- Asthma

Are you allergic or reacted adversely to:

- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Ibuprofen
- Latex
- Other _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medication
- Antidepressants or tranquilizers
- Insulin or other diabetes medication
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medication
- Other: _____

Women:

- May be pregnant
- Expected delivery date: _____
- Taking hormones or contraceptives

Please list current medications: + _____

Patient Signature: _____

Date: _____