MABRY, AKHRASS & MCCARY, DDS
DENTAL HEALTH HISTORY UPDATE

Patient's Name: _____
Last First Middle Initial

Birthdate:_____ **Social Security #**_____

Male_____ Female_____ Single_____ Married_____ Widowed_____ Divorced_____

Complete Address:_____ **E-Mail Address**:_____

Home Phone Number:_____ **Cell Phone:**_____ **Work Phone:**_____

CONFIRM MY APPTS BY: CELL PHONE_____ TEXT MESSAGE_____ E-MAIL_____ HOME NUMBER_____

Dental Insurance:_____ **Subscriber Name:**_____ **Sub birthdate**:_____

Ins Subscriber #_____ Group #_____

MEDICAL HISTORY

Reason for today's visit:_____

Name of Family Doctor:_____ Date of last visit_____

Have you had any serious illnesses or operations? _____ Describe_____

Have you ever been told by your physician that you must take an antibiotic prior to dental procedures due to a recent joint replacement, heart surgery, etc. _____ YES _____NO

Have you ever had a blood transfusion? Yes____ No____ if yes, give approximate date_____
(Women) Are you pregnant Yes____ No____ Nursing? Yes___ No___ taking birth control pills? Yes____ No____

Check ( ) if you have had any of the following:

____ AIDS
____ Anemia
____ Arthritis, Rheumatism
____ HIV positive
____ Jaw pain
____ Artificial Joints
____ Asthma
____ Back Problems
____ Blood Disease
____ Cancer
____ Chemical Dependency
____ Chemotherapy
____ Circulatory Problems
____ Cortisone Treatments
____ Cough, Persistent
____ Cough up blood
____ Shortness of breath
____ Skin rash
____ Epilepsy
____ Fainting
____ Glaucoma
____ Headaches
____ Heart Murmur
____ Heart Problems
Describe:_____
____ Hemophilia/Excessive Bleeding
____ Hepatitis
____ High blood pressure
____ High Cholesterol
____ Artificial Heart Valves
____Migraines
____ Kidney disease
____ Liver disease
____ Mitral Valve Prolapse
____ Nervous Problems
____ Pacemaker
____ Psychiatric Care
____ Radiation Treatment
____ Respiratory Disease
____ **Sleep Apnea**
____ Rheumatic Fever
____ Scarlet Fever
____ ADD/ADHD
____ Diabetes
____ Reflux
____ Stroke
____ Swelling feet/ankles
____ Thyroid problems
____ Tobacco habit
____ Tonsillitis
____ **Tuberculosis**
____ Ulcer
____ Venereal disease

MEDICATIONS

List medications you are taking:_____
_____
_____
_____

ALLERGIES

____ Aspirin
____ Barbiturates (Sleeping Pills)
____ Codeine
____ Local anesthetic
____ **Latex**
____ Penicillin
____ Sulfa drugs
____ Other_____
_____

List **Supplements** you are taking, i.e., garlic, vitamins, etc _____
_____

The above information is complete and accurate to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE:_____ **SIGNATURE:**_____