BURL Oak CENTRE DENTISTRY

Reviewed by: _____

Medical History Update

We would like to update your medical records at this time to help us provide the best possible care for you. **Your oral health is directly linked to your overall health.** Please help us by completing this information. Thank you.

Dr. Shefali Tuli

First Name:_____ **Last Name:** _____ **Date:**_____

Did Your Emergency Contact Change? In case of an emergency, who should we call?

Name: _____ Relationship to you: _____

Home Tel #: _____ Work Tel #: _____ Cell #: _____

Updated Medical History:

Do you currently have, *(or within the last 6 months, had)* any of the following?

- ☐ AIDS/ HIV
- ☐ Allergic to: _____
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder: _____
- ☐ Bronchitis
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital Heart Lesions
- ☐ Crohn's Disease
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Rhythm disorder
- ☐ Heart Surgery
- ☐ Hepatitis A B C _____
- ☐ High Cholesterol
- ☐ Hyper/hypo Glycemia
- ☐ Inflammatory Bowel Disease
- ☐ Mitral Valve Prolapse
- ☐ Migraines
- ☐ Blood Pressure ☐ High ☐ Low
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Mental Disorder
- ☐ Nervous System Disorder
- ☐ Organ Transplant/Medical Implant
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever (Scarlet Fever)
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ _____
- ☐ _____

Usual Blood Pressure: _____/_____ (if known)

For Women: Are you currently Pregnant? ☐ Yes ☐No

Due Date: _____

Are you under the care of a Medical Specialist? Y N Type_____ **Name** _____

Medications - Please List Your Regular Medications Below:

_____

_____

_____

Sign below to confirm that the above information is accurate, to the best of your knowledge.

Patient Signature:_____