WEST ASHLEY
FAMILY DENTISTRY

Patient Medical History Update Form

Please take a few minutes to carefully read over and answer the following questions to help us treat you safely.
If you have any questions, please let us know, and we will be glad to assist you.

Patient Name _____ Date of Birth _____ Today's Date _____

Is there anything that you would like to change about your teeth?

_____

Medical History

Physician Name _____ Date of Last Visit _____

Have you been hospitalized since the last time you visited our office? ◯ Yes ◯ No

If yes, please list date and reason _____

Have you been diagnosed with diabetes? ◯ Yes ◯ No

Have you been diagnosed with high blood pressure? ◯ Yes ◯ No

Has your physician recommended you take antibiotic prophylaxis prior to dental visits? ◯ Yes ◯ No

If yes, please list reason _____

Do you have an allergy to ☐ Local Anesthetic ☐ Penicillin ☐ Latex
☐ Other _____

Are You Pregnant? ◯ Yes ◯ No Due Date _____ Are you nursing? ◯ Yes ◯ No

Are you taking birth control pills? ◯ Yes ◯ No

Please list any medications you are taking and what you are taking it for:

_____

Pharmacy Name _____ Pharmacy Number _____

Are you experiencing ☐ Fever ☐ Shortness of breath ☐ Dry Cough ☐ Runny Nose ☐ Sore Throat ☐ Loss of taste/smell

Within the last 14 days have you traveled: ☐ Within the US ☐ Outside the US If yes to either, where? _____

Have you or anyone you have been in contact with been diagnosed with COVID-19? ◯ Yes ◯ No

By typing your name below, you ceritfy that all information on this form is correct to the best of your knowledge.

Name of Patient or Guardian _____

Once completed, please save this form and email it to westashleyfamilydentistry@gmail.com