

MEDICAL UPDATE

Date:_____

Piesse list any medications that you are not currently taking. **Piesse** list any medications that you are not currently taking. **Piesse** list any allergies to medications allergies:	Name (Last, First, M.I.):		Date of Birth:	Phone:	Phone:				
	MEDICATIONS								
Please list any allergies to metication or any other allergies	Please list any medications that you are currently taking. Place a checkmark next to any that needs refills.								
Please list any allergies to medications or any other allergies:									
Please list any allergies to medications or any other allergies: Please check here if you do not have any medication allergies Please check here if you are not or any medications Please check here if you are not or any medication Please check here if you are not or any medication Please check here if you are not or any medication Please check here if you are not or any medication Please check here if you do not have any medication allergies Please check here if you are not or any medication Please check here if you are not or any medication Please check here if you do not have any of the document? Please check here if you are not or any in please check any of the document? Please check here if you are not or any in please check any of the document? Please check here if you are not only in please check here if you are not only in please check here if you are not only in please check any of the document? Please check here if you are not only in please check any of the document? Please provide us with a copy of the document? Please provide us with a copy of the document? Please provide us with a copy of the document? Please check any of the dollar treatment? Please or others? Please check any of the following dental treatment? Pl									
Please check here if you do not have any medication allergies									
Name of Physician:	Please list any allergies to medications or any other allergies:								
Name of Physician:	Please check here if you do <u>not</u> have any medication allergies Please check here if you are not on any medications								
Have you been seen in the ER in the last 10 days?	RECENT HISTORY								
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?	Name of Physician:			Phone:					
Please explain brieffly: Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document): Please provide us with a copy of the document provided provid	Have you been seen in the ER in the last 10 days?					□ Yes		No	
Please explain briefly: Who is your health care proxy? (Please provide us with a copy of the document): Yes No No No No No No No N	Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?					□ Yes		No	
No is your health care proxy? (Please provide us with a copy) of the document):	Do you have any URGENT medical needs that require you to be seen immediately?					□ Yes		No	
No you have an advance directive document? (Please provide us with a copy)	Please explain briefly:								
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.) Do you have thoughts of hurting yourself or others? Would you like to see a courselor? Would you like to see a courselor? For pediatric patients: is the patient in need of immunizations or a time-sensitive physical? Do you need an antibiotic prior to dental treatment? Do you need an antibiotic prior to dental treatment? Do you need an antibiotic prior to dental treatment? Do you need an antibiotic prior to dental treatment? Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need assistance with: Please check any of the following that you need a	Who is your health care proxy? (Please provide us with a copy of the document):								
Do you have thoughts of hurting yourself or others? Would you like to see a counstor? For pediatric patients: is the patient in need of immunizations or a time-sensitive physical? Do you need an antibiotic prior to dental treatment? Have you ever had any complications following dental treatment? Please check any of the following that you need assistance with: Reading/Writing Housing Health Insurance Language/Interpreter Transportation Anxiety Fainting Radiation Treatment Rheumatic Fever Pregnancy, Due Date: Anxiety Fainting Radiation Treatment Rheumatic Fever Sinus Problems Attificial Joints Heart Murmur Glaucoma Thyroid disease Artificial Joints Heart Murmur Glaucoma Thyroid disease Attificial Sinus Problems Rheumatism Tumors Blood disease Hejatitis Rheumatism Tumors Blood disease Hegatitis Throat Tumors Dizziness Respiratory Problems Head injuries Faileney Respiratory Problems Head injuries Faileney Respiratory Problems Head injuries Blood Dizziness Respiratory Problems Head injuries Dizziness Respiratory Problems Mental Disorders Blood Dizziness Respiratory Problems Head injuries Dizziness Respiratory Problems Mental Disorders Dizziness Respiratory Problems Mental Disorder	Do you have an advance directive document? (Please provide us with a copy)					□ Yes		No	
Would you like to see a counselor? For pediatric patients: is the patient in need of immunizations or a time-sensitive physical? Do you need an antibiotic prior to dental treatment? If yes, please explain: Please check any of the following that you need assistance with: Reading/Writing Housing Health Insurance Language/Interpreter Transportation HEALTH ISSUES AIDS/HIV Fainting Radiation Treatment Rebumatic Fever Sexually Transmitted Infection Anxiety Fainting Growths Liver Disease Stroke Arthritis Hay Fever Pacemaker Sinus Problems Asthma/Emphysema Heart Murmur Glaucoma Thyroid disease Artificial Joints Heart Murmur Glaucoma Thyroid disease Artificial Joints Heart Murmur Glaucoma Thyroid disease Blood disease Hejatitis Throat Tuberculosis Cancer High Blood Pressure Rheumatism Tumors Cancer High Blood Pressure Rheumatism Tumors Depression Jaundice Lungs Vision problems Diaziness Respiratory Problems Head injuries Diaziness Re	Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)					□ Yes		No	
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?	Do you have thoughts of hurting yourself or others?					□ Yes		No	
Do you need an antibiotic prior to dental treatment? No No No No No	Would you like to see a counselor?					□ Yes		No	
Have you ever had any complications following dental treatment? Yes No No	For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?					□ Yes		No	
If yes, please explain: Please check any of the following that you need assistance with: Reading/Writing	Do you need an antibiotic prior to dental treatment?					□ Yes		No	
Please check any of the following that you need assistance with: Reading/Writing	Have you ever had any complications following dental treatment?					□ Yes		No	
Reading/Writing	If yes, please explain:								
HEALTH ISSUES AIDS/HIV	Please check any of the following that you need assistance with:								
□ AIDS/HIV □ Excessive Bleeding □ Rheumatic Fever □ Pregnancy, Due Date: □ Anxiety □ Fainting □ Radiation Treatment □ Rheumatic Fever □ Ability to sleep □ Growths □ Liver Disease □ Sexually Transmitted Infection □ Arthritis □ Hay Fever □ Pacemaker □ Sinus Problems □ Asthma/Emphysema □ Heart Disease/ Heart Attack □ Ulcers □ Stroke □ Artificial Joints □ Heart Murmur □ Glaucoma □ Thyroid disease □ Blood disease □ Hepatitis □ Throat □ Tuberculosis □ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Mental Disorders	☐ Reading/Writing ☐ Ho	ousing	nsurance	□ Language/Interpre	eter 🗆 Tra	nsportation			
□ Anxiety □ Fainting □ Radiation Treatment □ Rheumatic Fever □ Ability to sleep □ Growths □ Liver Disease □ Sexually Transmitted Infection □ Arthritis □ Hay Fever □ Pacemaker □ Sinus Problems □ Asthma/Emphysema □ Heart Disease/ Heart Attack □ Ulcers □ Stroke □ Artificial Joints □ Heart Murmur □ Glaucoma □ Thyroid disease □ Blood disease □ Hepatitis □ Throat □ Tuberculosis □ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Foilensy □ Alcohol / Drug Dependency (past or □ Mental Disorders	HEALTH ISSUES								
□ Ability to sleep □ Growths □ Liver Disease □ Sexually Transmitted Infection □ Arthritis □ Hay Fever □ Pacemaker □ Sinus Problems □ Asthma/Emphysema □ Heart Disease/ Heart Attack □ Ulcers □ Stroke □ Artificial Joints □ Heart Murmur □ Glaucoma □ Thyroid disease □ Blood disease □ Hepatitis □ Throat □ Tuberculosis □ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries	□ AIDS/HIV] AIDS/HIV □ Excessive Bleeding		☐ Rheumatic Fever ☐ Pregnancy, ☐			ue Date:		
Arthritis	Anxiety			□ Radiation Treatment					
Asthma/Emphysema	☐ Ability to sleep	□ Growths		☐ Liver Disease					
□ Artificial Joints □ Heart Murmur □ Glaucoma □ Thyroid disease □ Blood disease □ Hepatitis □ Throat □ Tuberculosis □ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Fnilensy □ Alcohol / Drug Dependency (past or □ Mental Disorders	□ Arthritis	☐ Hay Fever		□ Pacemaker	Problems				
□ Blood disease □ Hepatitis □ Throat □ Tuberculosis □ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Fpilepsy □ Alcohol / Drug Dependency (past or □ Mental Disorders	☐ Asthma/Emphysema ☐ Heart Disease/ Heart Attack			□ Ulcers	□ Stroke	□ Stroke			
□ Cancer □ High Blood Pressure □ Rheumatism □ Tumors □ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Fnilensy □ Alcohol / Drug Dependency (past or □ Mental Disorders	☐ Artificial Joints	ints		□ Glaucoma	Glaucoma Thyroid disease				
□ Depression □ Jaundice □ Lungs □ Vision problems □ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Fpilepsy □ Alcohol / Drug Dependency (past or □ Mental Disorders	□ Blood disease	☐ Hepatitis		□ Throat	□ Tuberculosis				
□ Diabetes □ Kidney Disease □ Stomach Problems □ Other □ Dizziness □ Respiratory Problems □ Head injuries □ Epilepsy □ Alcohol / Drug Dependency (past or □ Mental Disorders	□ Cancer	☐ High Blood Pressure		□ Rheumatism	☐ Tumors				
□ Dizziness □ Respiratory Problems □ Head injuries □ Alcohol / Drug Dependency (past or □ Mental Disorders	□ Depression	☐ Jaundice		□ Lungs	☐ Vision problems				
☐ Alcohol / Drug Dependency (past or ☐ Mental Disorders	□ Diabetes	☐ Kidney Disease		☐ Stomach Problems ☐ Other					
	□ Dizziness			☐ Head injuries					
	□ Epilepsy		st or	☐ Mental Disorders					

Signature: