Green Bench Dental, LLC
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PATIENT MEDICAL HISTORY UPDATE

Your Name……Date…….....

Your Physician is:.....Office Phone.....Date of Last Exam.....

Are you under medical treatment for chronic or acute conditions? ( )Yes ( )No If yes, please explain.....
.....

Have you ever been hospitalized within the last year? ( )Yes ( )No If yes, please explain.....
.....

Have you ever been to a cardiologist?( )Yes ( )No Have you had cancer radiation treatment near your jaws?.. ( )Yes ( )No
Do you use tobacco?.....( )Yes ( )No Do you vape?.....( )Yes ( )No
Do you use marijuana? .....( )Yes ( )No Do you use dip, chew or snuff or snort.....( )Yes ( )No
Have you taken bisphosphonates, like Fosamax, Actonel, Boniva? ( )Yes ( )No...If yes, when?.....

Please list all ALLERGIES: Allergic reactions may include hives, swelling and difficulty breathing. Allergies may include antibiotics such as penicillin, other medicines, aspirin, metals, latex:.....
.....
Please list all sensitivities or adverse reactions to medications: Reactions usually involve nausea, vomiting or malaise, and pain medications are the most common:.....
.....
For **WOMEN** Only: Are you pregnant or think you may be pregnant? ( )Yes( )No Are you nursing? ( )Yes ( )No
Are you taking oral contraceptives? ....( )Yes ( )No If yes, Type:.....

Please list all current and past medical conditions. Please check appropriate answer boxes.

High Blood Pressure.... ( )Yes ( )No	Heart Disease..... ( )Yes ( )No	Chest Pains..... ( )Yes ( )No
Heart Attack..... ( )Yes ( )No	Cardiac Pacemaker..... ( )Yes ( )No	Easily Winded..... ( )Yes ( )No
Rheumatic Fever..... ( )Yes ( )No	Heart Murmur..... ( )Yes ( )No	Stroke..... ( )Yes ( )No
Swollen Ankles..... ( )Yes ( )No	Angina.....…( )Yes ( )No	Hay Fever/Allergies.. ( )Yes ( )No
Fainting/Seizures..... ( )Yes ( )No	Frequently Tired..... ( )Yes ( )No	Tuberculosis..... ( )Yes ( )No
Asthma..... ( )Yes ( )No	Anemia.....( )Yes ( )No	Radiation Therapy... ( )Yes ( )No
Low Blood Pressure.... ( )Yes ( )No	Emphysema.....( )Yes ( )No	Glaucoma..... ( )Yes ( )No
Epilepsy/Convulsions.. ( )Yes ( )No	Cancer.....( )Yes ( )No	Recent Weight Loss ( )Yes ( )No
Leukemia.....… ( )Yes ( )No	Arthritis..... ( )Yes ( )No	Liver Disease..... ( )Yes ( )No
Diabetes.....( )Yes ( )No	Joint Replacement/Implant . ( )Yes ( )No	Heart Trouble.....…( )Yes ( )No
Kidney Diseases..... ( )Yes ( )No	Hepatitis/Jaundice.....( )Yes ( )No	Respiratory Problem ( )Yes ( )No
AIDS or HIV Infection... ( )Yes ( )No	Sexually Transmitted Disease( )Yes ( )No	Thyroid Problem..... ( )Yes ( )No
Stomach disease/Ulcers( )Yes ( )No	Blood disease.....….....( )Yes ( )No	Chemotherapy.....( )Yes ( )No
Artificial Heart Valve..... ( )Yes ( )No	Anticoagulant Use..... ( )Yes ( )No	Osteoporosis.....( )Yes ( )No

Please list Rx medications and dosage	**Prescribed for? (medical condition)**	**Doctor's name on Rx**
Example: Lisinopril 10mg/day	High blood pressure.....	Dr. John Doe.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Or, please attach a copy of a similar list! (We will be glad to copy for you)
Please list all over the counter medicines, including vitamins, herbal supplements, analgesics:.....
.....

Doctor's notes.....