2525 South Wadsworth Blvd. #23
Lakewood CO 80227

(303)985-0909
happytooth@toothmansion.com

Mark Granger, D.D.S.

www.toothmansion.com

Medical Update

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please take a moment to update your medical history.

Please mark any of the following to indicate "Yes" in response to the question:

- ☐ Would you consider yourself to be in good health?
- ☐ Have you ever had complications following medical or dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized or had an emergency room visit within the last 5 years?
- ☐ Do you require the use of corrective lenses (contacts or glasses) or hearing aids?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previos questions are marked, please explain:

Please indicate if you have experienced any of the following:

☐ Acid Reflux	☐ AIDS/HIV	☐ Allergies	☐ Amoxicillin Allergy
☐ Anemia	☐ Angina/Chest Pain	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Cancer	☐ CHF/Heart Failure
☐ Codeine Allergy	☐ Diabetes	☐ Dizziness	☐ Eating Disorder
☐ Emphysema	☐ Endocarditis	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Hay Fever	☐ Head Injuries
☐ Hearing Aid	☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur
☐ Heart Surgery	☐ Hemophilia	☐ Hepatitis	☐ High Blood Pressure
☐ Irregular Heart Beat	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Low Blood Pressure	☐ MetabisulfiteAllergy	☐ Migraines/Headaches	☐ Multiple Sclerosis

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☐ Nervous Disorders	☐ Oral Contraceptives	☐ Pacemaker	☐ Pain in Jaw Joints
☐ Penicillin Allergy	☐ Premed Amoxicillin	☐ Psychiatric Therapy	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Shortness of Breath	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Sulfa Drug Allergy	☐ Swollen Ankles
☐ Thyroid Condition	☐ Tobacco Use	☐ Tuberculosis	☐ Tumors
☐ Tylenol Allergy	☐ Ulcers/Colitis	☐ Venereal Disease/STD	☐ Yellow Jaundice

Please list prescription and nonprescription medications. The dosages and why you are taking them? If you have a written list we can scan this into your chart.

WOMEN ONLY:

☐ Are you pregnant now?

☐ Are you trying to get pregnant or possibly be pregnant now?

☐ Do you practice birth control?

☐ Are you nursing?

If you are pregnant what is your due date?

Do you have any other health issues or allergies?

Signature: _____ Date:

Response Date: