CROSSINGS CLINIC
dental sleep apnea center

LOUISVILLE DENTAL
SLEEP MEDICINE, PLLC

Medical History Update Form

Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ State ____ Zip _____ Business Phone _____

Email Address _____ Cell Phone _____

Medical History Update

Has there been any change in your general health within the past year? _____

_____

The date of my last physical was _____

Are you now under the care of a physician? _____

If so, what is the condition for which you are being treated? _____

If you are you taking any new medications (including non-prescription medication) since your last visit,

please list them _____

Medical Contacts

Crossings Clinic coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers below:

Doctor _____ Phone _____

Doctor _____ Phone _____

Doctor _____ Phone _____

Dental History Update

How long has it been since your last dental appointment? _____

Do you have lumps or sores in your mouth now? _____

Have you ever been treated for gum or periodontal disease? _____

If so when? _____ How was the infection treated? _____

Do your gums bleed? _____If so when? _____

Do you clench or grind your teeth? _____

Do you experience frequent canker sores? _____

Do you have fever blisters? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information above have been answered to my satisfaction. I will not hold the doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature _____ Date _____