Medical History Update Form

MOONLIGHT DENTISTRY

Patient Information

Full Name: _____

Date of Birth: _____ Today's Date: _____

Since your last visit, have there been any changes to your medical history?

☐ No changes ☐ Yes (please complete below)

Please check any that apply:

☐ New medical condition or diagnosis

☐ Hospitalization or surgery

☐ New medications

☐ Medication changes

☐ Allergies (new or changed)

☐ Pregnancy

☐ Smoking or vaping status changed

☐ Alcohol or recreational drug use changed

☐ Joint replacement

☐ Heart condition or heart surgery

☐ Cancer diagnosis or treatment

☐ Diabetes

☐ High blood pressure

☐ Osteoporosis or bone-strengthening medications (e.g., bisphosphonates, Prolia®)

☐ Blood thinners (e.g., Warfarin, Eliquis®, Xarelto®)

☐ Other:

If you answered "Yes," please provide details:

Current Medications (if changed):

Allergies:

I confirm that the information provided above is accurate and complete to the best of my knowledge.

Patient / Guardian Signature: _____

Date: _____

Reviewed by: _____