HEALTH HISTORY UPDATE

Patient Name_____DOB_____Male □ Female □

_____

Address ☐**new?** city state zip

Home phone #_____ Work phone_____ Cell phone _____

SS#_____ Email Address _____

Dental Insurance Co_____ Phone #_____

Name of insured _____ Group# _____

Insured SS _____ Insured ID _____ Insured DOB _____

NOTE: A change in your health status should be reported to the office at the earliest possible time. To the best of my knowledge, the foregoing questions have been answered accurately.

Currently under the care of a physician? Yes □ No □
If yes for what condition?_____
Are you taking any medication regularly? Yes □ No □
If yes, list medications and for what reason taken:

_____
_____
_____
_____
_____
_____

Do you have, or ever had an allergic reaction to:

Local Anesthetics	Yes □	No □
Penicillin	Yes □	No □
Sulfa Drugs	Yes □	No □
Aspirin	Yes □	No □
Codeine	Yes □	No □
Latex	Yes □	No □
Bandaid Only	Yes □	No □
Any severe food allergies?	Yes □	No □

Do you suffer from Dry-Mouth? Yes □ No □
Mild □ Moderate □ Severe □
Number of alcoholic drinks per week? _____

In the last 6 months, have you taken one of the following Biophosphonate derivatives for the prevention of Osteoporosis? Yes □ No □
Circle if any: Fosamax, Actonel, Didronel, Boniva, Avedia, Skelid, Zometa, Prolia, _____

Circle if any: heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular heartbeat

History of heart issues:

Valvulitis	Yes □	No □
Endocarditis	Yes □	No □
Artificial heart valve	Yes □	No □
Heart Valve Repair	Yes □	No □
Congenital Heart Conditions	Yes □	No □
Unrepaired Cyanotic CHD	Yes □	No □
Heart/Organ Transplants	Yes □	No □
Palliative Shunts & Conduits	Yes □	No □
Stroke	Yes □	No □

Circle if any: abnormal blood pressure, excessive bleeding or anemia
Blood thinners? If yes, name? _____ Yes □ No □
Circle if taken daily: Fish Oil, Aspirin or Ibuprofen

Have you been told to take antibiotics prior to dental treatment? Reason: _____ Yes □ No □
Any prosthetic Joint replacement? Yes □ No □
Where and when was the surgery? _____
_____

Auto-immune disease? Yes □ No □
Name? _____
Rheumatoid arthritis? Yes □ No □
Circle if any: convulsions, fainting spells or epilepsy?
Circle if any: Parkinsons, dementia, other neurological disorders

Circle if any asthma, Tuberculosis or COPD
Mild □ Moderate □ Severe □
Tobacco use? Yes □ No □
If yes type & quantity: _____

Circle if any Cancer, Tumors, Growths, Radiation Treatment or Chemotherapy. When ? _____
Are you currently being treated? Yes □ No □

Diabetic? Type? _____ Yes □ No □

Circle if any Hepatitis, jaundice, or liver disease, kidney problems or renal dialysis
Circle if any: HIV, AIDS, Syphillis
Do you suffer with GERD? (*Acid Reflux*) Yes □ No □

For women: Are you pregnant? Yes □ No □
Circle if you are taking any: hormones or birth control

Are there any other problems about your health of which you are aware? _____
_____

_____
Signature Date
If other than patient, indicate relationship:_____