Health History Update

PLEASE PRINT YOUR NAME

Medical History

	Yes	No
Are your under a physician's care now? Why? Who?	☐	☐
Date of last physical exam		
Have you ever been hospitalized or had an operation? Describe	☐	☐
Have you ever had a serious injury to your head or neck? Describe	☐	☐
Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What?	☐	☐
Are you on a special diet? Describe	☐	☐
Are you allergic to any medications or substances? Please check box for allergic reaction below	☐	☐

Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex Rubber __ Other

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Describe

Do you have or have you ever had any of the following:
(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐
Scarlet Fever*	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joints*	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS*	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A & C (Infectious)	☐	☐	Herpes (Cold Sore)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Drug Addiction/Use	☐	☐
Alcohol Use/Abuse	☐	☐	Fever Blisters	☐	☐	Hepatitis C	☐	☐	Genital Herpes	☐	☐
Depression	☐	☐	ADD/ADHD	☐	☐	Stroke	☐	☐	Snoring / Sleep Apnea	☐	☐
						Seizure	☐	☐			

Have you ever had any other serious illness not checked above? Describe ☐ ☐

Are you currently taking Bisphosphonate ☐ Yes ☐ No

Do you wish to talk to the dentist privately about any problem? ☐ ☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: ☐ *I DO WANT A COPY OF 'NOTICE'* ☐ *I DO NOT WANT A COPY OF 'NOTICE'*

Date:

☐ *Adult Patient* ☐ *Father* ☐ *Husband* ☐ *Mother* ☐ *Wife* ☐ *Guardian*

PLEASE SIGN ABOVE

Reviewed by Doctor Date BP

History review and significant findings:

Medical History Update

Date	Comments	Signature