

MEDICAL HEALTH HISTORY UPDATE

Please complete both sides of page

Date: _____

Patient Name: _____

Home Phone #: (_____) _____

Cell Phone #: (_____) _____

Email address: _____

DOB: _____

Physician's Name _____

Physician's Phone Number: _____

Your current health is? (Circle) Good Fair Poor

Are you currently under the care of a physician for a health condition? Yes No If yes, for what condition: _____

Are you taking medications? Yes No If yes, then please list prescriptions: _____

Are you allergic to or had a bad reaction to any of the following: (Circle Y or N)

- | | | | | | |
|---|---|--------------|---|---|--------------|
| Y | N | Penicillin | Y | N | Tetracycline |
| Y | N | Erythromycin | Y | N | Sulfa |
| Y | N | Aspirin | Y | N | Latex |
| Y | N | Metals | | | |
| Y | N | Anesthetics | | | |

Have you had a bad reaction to any other medicine or materials? Y N If yes, please list : _____

Please list all over-the-counter medications or "supplements" you are taking:

Have you experienced any of the following diseases or medical problems? (Circle Yes or No)

- | | | | | | | | | |
|---|---|-------------------------|---|---|------------------------------|---|---|------------------------------|
| Y | N | High Blood Pressure | Y | N | Epilepsy or seizures | Y | N | Cancer or Tumors |
| Y | N | Abnormal Bleeding | Y | N | Emphysema | Y | N | Kidney problems |
| Y | N | Stroke | Y | N | Tuberculosis | Y | N | Venereal disease or STD's |
| Y | N | Heart attack | Y | N | Persistent cough | Y | N | HIV+/ AIDS |
| Y | N | Heart Surgery | Y | N | Diabetes | Y | N | Artificial bones or Joints |
| Y | N | Low Blood Pressure | Y | N | Fainting spells | Y | N | Chemo or radiation treatment |
| Y | N | Heart Valve replacement | Y | N | Frequent or severe headaches | Y | N | Drug or alcohol abuse |
| Y | N | Heart murmur | Y | N | Hepatitis or liver disease | Y | N | Herpes or Cold sores |
| Y | N | Pacemaker | Y | N | Glaucoma | Y | N | Steroid Therapy |
| Y | N | Asthma | Y | N | Arthritis | Y | N | Thyroid issues |
| Y | N | Anemia | Y | N | Colitis or Ulcers | Y | N | Psychiatric episodes |

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Are you now taking, or have you ever taken any medications to strengthen your bones or increase your bone density? Please circle: Y N

If yes, what medication? _____

Have you ever been told that you should take antibiotics prior to dental work or dental cleanings? Y N

Do you smoke or use tobacco in any form? Y N

Please list any serious medical condition(s) that you have experienced: _____

Women Only:

Are you pregnant? Y N Unsure If yes, how far along are you (months)? _____

Are you nursing? Y N Are you taking birth control medication? Y N

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical/health status.

Signature: _____ Date: _____

Office Notes: _____
