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MEDICAL HEALTH HISTORY UPDATE

Please complete both sides of page

Patient Name ____ **Date:** ________________________

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 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	Dental Anesthetics

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

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

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

____

Have you had an artificial bone or joint replacement? Y N Date of Procedure____________________________

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	Chemo or radiation treatment
Y	N	Low Blood Pressure	Y	N	Fainting spells	Y	N	Drug or alcohol abuse
Y	N	Heart Valve replacement	Y	N	Frequent or severe headaches	Y	N	Herpes or cold sores
Y	N	Heart murmur	Y	N	Hepatitis or liver disease	Y	N	Steroid Therapy
Y	N	Pacemaker	Y	N	Glaucoma	Y	N	Thyroid issues
Y	N	Asthma	Y	N	Arthritis	Y	N	Psychiatric episodes
Y	N	Anemia	Y	N	Colitis or Ulcers			

** Please turn page over

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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: ______________________________

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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: ______________________________

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