HEALTH HISTORY UPDATE

Patient Name_____

Date:_____

How is your general health?_____

Has there been any change in your general health since your last visit to our office? Please describe:

_____

Have you had any surgeries since your last visit?_____

Are you under a physician's care at this time?_____

Name of physician:_____

Condition being treated or observed:_____

Do you have any type of heart problems or problems with blood pressure?_____

Are you taking any medications at this time? Please list:_____

Are you now taking or planning to begin taking any bisphosphonates (i.e., Fosamax, Aredia, Zometa, Boniva, etc.)?

_____

Do you have any allergies? (drugs/latex/metals)_____

Do you have a joint replacement? Yes No When?_____

Are you pregnant? Yes No M

Have you ever had any of the following diseases or medical problems? Please Circle Y or N

Y N Heart trouble/ attack	Y N Stroke	Y N Sinus Trouble
Y N Heart murmur as a child	Y N Diabetes	Y N Rheumatic Fever
Y N Heart murmur currently	Y N Fainting or dizzy spells	Y N Jaundice
Y N Heart Pacemaker	Y N Emphysema	Y N Chemotherapy
Y N Mitral valve prolapse	Y N Blood transfusions	Y N Radiation treatment
Y N Artificial heart valve	Y N Anemia	Y N Cancer (what kind?)_____
Y N Artificial joint	Y N Psychiatric Treatment	Y N Bulimia
Y N Hepatitis	Y N Ulcers	Y N Asthma
Y N HIV + / AIDS / ARC	Y N Epilepsy or Seizures	Y N Arthritis
Y N Tuberculosis	Y N High Blood pressure	Y N Fever Blisters
Y N Drug/Alcohol abuse	Y N Cortisone steroid) medicine	Y N Hemophilia

Are you allergic to any of the following?

Y N Codeine Y N Dental Anesthetics Y N Penicillin Y N Erythromycin Y N Clindamycin Y N Latex

Please list any other drugs or metals that you are allergic to:_____

Please list all medications/herbs/over the counter drugs you are taking and *why* you are is taking them.

1.)_____	2)_____	3)_____
for_____	for_____	for_____
4)_____	5)_____	6)_____
for_____	for_____	for_____

Please list any other medical condition/congenital abnormalities that you have been treated or are being treated for:

_____

Is there any other health (medical or dental) information that we should know?_____

_____

_____ _____

Patient Signature Date