HEALTH HISTORY UPDATE

Date_____

Name_____ Date of Birth_____

Address_____City_____ST_____Zip_____

Home Ph_____ Cell_____ SSN_____

Employer_____Work Ph_____

Emergency Contact Person
Name_____ Phone_____Relationship_____
Name of your physician_____ Phone_____
Have you had a serious illness or been hospitalized?_____
If yes, explain below with dates_____

1. Are you currently under the care of a physician?	Yes	No
2. Do you have or have you ever had a heart murmur, leaky value or MVP?	Yes	No
3. Do you get pains in your heart or chest angina?	Yes	No
4. Have you had any heart disease such as heart attack or stroke?	Yes	No
5. Do you have high blood pressure?	Yes	No
6. Have you had jaundice or hepatitis?	Yes	No
7. Have you been treated for a seizure disorder?	Yes	No
8. Have you had a tumor or disease that required x-ray, radium, or cobalt treatment?	Yes	No
9. Have you had excessive or prolonged bleeding following a cut or extraction?	Yes	No
10. Have you had any trouble with previous dental treatment?	Yes	No
11. Have you ever had any reaction to Novocain?	Yes	No
12. Have you had TMJ pain, restricted jaw opening, or grind your teeth?	Yes	No
13. Do you have soreness in your mouth now?	Yes	No
14. Are you a diabetic?	Yes	No
15. Are you pregnant or nursing at this time?	Yes	No
16. Are you HIV positive or do you have AIDS?	Yes	No
17. Do you have any type of artificial implant or joint replacement?	Yes	No
If yes, what type and year_____		
18. Do you use any form of tobacco? If so how much?_____	Yes	No
19. Do you have seasonal allergies?	Yes	No
20. Have you had rheumatic fever?	Yes	No

21. Please fill in the following:
Medication Allergies:_____
Medication List:_____
Diseases or Conditions:_____
22. How would you liked to be contacted for your appointments?
Phone #_____ or Email_____