Updated Patient Health History

Patient Name: _____

Phone Number: _____ Email address: _____

1. Has there been any change in your general health within the past year? - - - - - - - - - - - - - yes no
2. My last complete physical exam was on _____
3. Emergency contact information: _____
4. Are you now, or have been under the care of a physician in the last year? - - - - - - - - - yes no
   If so, when and why? _____
   The name and address of my physician is _____
5. Have you been hospitalized within the last year? - - - - - - - - - - - - - - - - - - yes no
   If so, what was the illness, accident or operation? _____
6. Please check if you have had any of the **following diseases or problems:**

☐ Heart (surgery, disease, attack, stent)	☐ Sinus Trouble	☐ Venereal Disease
☐ Chest Pain	☐ Hay Fever	☐ A.I.D.S or H.I.V positive
☐ Congenital Heart Disease	☐ Kidney Trouble	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Liver Disease	☐ Radiation Therapy
☐ High Blood Pressure	☐ Diabetes	☐ Chemotherapy
☐ Mitral Valve Prolapse	☐ Thyroid Problems	☐ Tumors or Cancer
☐ Artificial Heart Valve	☐ Ulcers	☐ Neurological Disorders
☐ Heart Pacemaker	☐ Arthritis/Rheumatism	☐ Epilepsy or Seizures
☐ Rheumatic Fever	☐ Cortisone Medicine	☐ Fainting or Dizzy Spells
☐ Stroke	☐ Artificial Joints (hip, knee, etc.)	☐ Psychiatric/Psychological Care
☐ Swollen Ankles	☐ Anemia	☐ Autism (Low, Med, High)
☐ Emphysema	☐ Hemophilia	☐ Glaucoma
☐ Chronic Cough	☐ Sickle Cell Disease	☐ Contact Lenses
☐ Tuberculosis	☐ Bleeding Disorders	☐ Hearing Problems
☐ Asthma	☐ Osteoporosis	☐ Frequent Urination/Thirsty
☐ Allergies or Hives	☐ Hepatitis A,B or C	☐ Other: _____

7. Any abnormal bleeding associated with previous extractions, surgery or trauma? - - - - - - - - - yes no
8. Are you taking any medicine, including any over-the-counter medications? - - - - - - - - - - yes no
   If so, what? _____
   _____
   _____
9. Are you allergic or have you reacted adversely to:

☐ Local Anesthetics	☐ Codeine or other narcotics
☐ Penicillin or other Antibiotics	☐ Latex
☐ Sulfa Drugs	☐ Seafood
☐ Barbiturates, Sedatives, or sleeping pills	☐ Other: _____
☐ Aspirin	
☐ Iodine	

10. Do you smoke? - yes no
11. Do you chew tobacco? - yes no

WOMEN:

12. Are you pregnant? - yes no
    If so, how many months _____
13. Are you nursing? - yes no
14. Have you taken Fosamax, Zometa, Aredia, or any other oral or IV treatment for bone tumors or osteoporosis? - - yes no

Patient/Guardian signature _____ ***Date*** _____

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Dentist Signature _____