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____

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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
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 Text #_____________________________________
    Email#____