**Health History Update**

**Medical History**

General Health: Excellent Good Fair Poor

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Taking Any Medications Now? Yes No

If Yes. Medication Name/Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have You Ever Had a Blood Transfusion? Yes No If yes, Approximate Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Ever Been Treated For (Please Check All That Apply):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | AIDS |  | Cortisone Treatments |  | HIV Positive |  | Rheumatic Fever |
|   | Anemia |  | Cough up Blood |  | Jaw Pain |  | Scarlet Fever |
|  | Arthritis, Rheumatism |  | Diabetes |  | Kidney Disease |  | Shortness of Breath |
|  | Artificial Heart Valve |  | Epilepsy/Seizures |  | Mitral Valve Prolapse |  | Skin Rashes |
|  | Artificial Joints |  | Fainting |  | Nervous Problems |  | Stroke |
|  | Asthma |  | Glaucoma |  | Osteoporosis |  | Swelling of Feet |
|  | Back Problems |  | Headaches |  | Pacemaker |  | Thyroid Problems |
|  | Blood Disease |  | Heart Murmur |  | Persistent Cough |  | Tobacco Habit |
|  | Cancer(any) |  | Heart Problems |  | Psychiatric Care |  | Tonsillitis |
|  | Chemical Dependency |  | Hemophilia |  | Radiation Treatments |  | Tuberculosis |
|  | Chemotherapy/Radiation |  | Hepatitis (Circle A,B,C) |  | Respiratory Disease |  | Ulcer |
|  | Circulatory Problems |  | High Blood Pressure |  | Liver Disease |  | Venereal Disease |

Have You Ever Taken Bisphosphonates (IV or Pill Form) such as Fosamax or Boniva? Yes No

Women:

|  |
| --- |
| \*NOTE: Taking antibiotics may interfere with the effectiveness of birth control pills. |

Are You Pregnant? Yes No

Taking Birth Control? Yes No

Allergies:

Penicillin Codeine Latex Local Injected Anesthetics

Other Allergies to Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History:**

Please Check If You Have Had Trouble With Any of the Following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Bad Breath |  | Grinding/Clenching Teeth |  | Sensitivity to Heat |
|  | Bleeding Gums |  | Loose Teeth or Broken Fillings |  | Sensitivity to Sweets |
|  | Clicking or Popping Jaw |  | Periodontitis |  | Sensitivity to Biting |
|  | Food Collection Between Teeth |  | Sores or Growths in Mouth |  | Sensitivity to Cold |

Do you have an unpleasant odor or taste in your mouth? Yes No

Are you happy with the appearance of your teeth? Yes No

Do your gums bleed when brushing? Yes No