HEALTH HISTORY UPDATE

Patient name: _____ **Date of Birth:** _____

Pharmacy's Name and Phone Number:_____
Have you ever been hospitalized or had a major operation? YES NO If yes, explain: _____
Have you ever had a serious head or neck injury? YES NO _____
Do you have Artificial Joints? YES NO If yes, Where:_____ Surgery Date _____
Have you been instructed/required to pre-medicate prior to a dental procedure YES NO If yes, explain: _____
Do you take, or have taken, Fen-phen or Redux? YES NO
Do you use tobacco? YES NO Do you snore? YES NO
For women: Are you pregnant? YES NO Due Date: _____ Are you nursing? YES NO

Place a mark on "yes " or "no" to indicate if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			**Epilepsy or Seizures**			**High Blood Pressure**			**Rheumatism**		
Alzheimer's Disease			**Excessive Bleeding**			**High Cholesterol**			**Scarlet Fever**		
Anemia			**Fainting/Dizziness**			**Hives or Rash**			**Shingles**		
Arthritis/Gout			**Frequent Cough**			**Hypoglycemia**			**Sinus Trouble**		
Artificial Heart Valve			**Frequent Headaches**			**Irregular Heartbeat**			**Sleep Disorder**		
Asthma			**Glaucoma**			**Kidney Disease**			**Stomach/Intestinal Disease**		
Blood Disease			**Heart Attack/Failure**			**Liver Disease**			**Stroke**		
Cancer			**Heart Murmur**			**Low Blood Pressure**			**Swelling of Limbs**		
Chemotherapy			**Heart Pacemaker**			**Lung Disease**			**Thyroid Disease**		
Cold Sores/Fever Blisters			**Heart Trouble/Disease**			**Mental Health Disorder**			**Tonsillitis**		
Congenital Heart Disorder			**Hemophilia**			**Mitral Valve Prolapse**			**Tuberculosis**		
Convulsions			**Hepatitis A**			**Pain in Jaw Joints**			**Tumors /Growths**		
Cortisone Treatments			**Hepatitis B or C**			**Radiation**			**Ulcers**		
Diabetes			**Herpes**			**Rheumatic Fever**			**Venereal Disease**		
Other condition(s):											

MEDICATIONS	**ALLERGIES**
List all your medications and supplements **No Medications ____** _____ _____ _____ _____ _____ _____ _____	Aspirin ___ **Not known drug allergies ___** Codeine ___ Iodine ___ Latex ___ Local Anesthetic ___ Penicillin ___ Sulfa ___ Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____