Health History Update

Name _____ Age_____ Date _____
Last First Middle

Address_____City _____ Zip_____

Home ( )_____ Work ( )_____ Cell ( ) _____ e-mail_____

HEALTH INFORMATION *Please answer each question for the patient.* *Please mark appropriate answer.* YES NO

1. Are you in good health? ❑ ❑
2. Have you been treated by a physician in the past two years? ❑ ❑
   If yes, for what? _____
3. Have you had any serious illness, operations, or been hospitalized in the past three years? ❑ ❑
   If yes, please explain _____
4. Are you currently taking any drugs or medicines? (including aspirin, pain pills or non-prescription drugs) ❑ ❑
   If yes, what? _____
5. Have you had any type of heart surgery? ❑ ❑
   If yes, please explain _____
6. Do you have artificial heart valves? ❑ ❑
7. Do you have a history of infective endocarditis? ❑ ❑
8. Do you have any serious congenital heart conditions? ❑ ❑
9. Do you have a cardiac transplant that has developed a problem with the heart valves? ❑ ❑
10. Have you had a blood transfusion since 1975? ❑ ❑
    If yes, when? _____
11. (Women) Are you pregnant? ❑ ❑
    Do you take birth control pills? ❑ ❑
    If yes, please be advised that antibiotics which may be given to you for oral infections may render your birth control pills ineffective. Therefore another form of birth control must be used for the duration of the menstrual cycle during which you take the antibiotic.
12. Are you sensitive or allergic to any drugs? (Penicillin, Tetracycline, Sulfa, Erythromycin, Novocain, Codeine, etc.) ❑ ❑
    If yes, what? _____
    What type of reaction do you have? _____
13. Do you have allergies to any metals or other substances? (including nickel, latex, clove oil, etc.) ❑ ❑
    If yes, what? _____
14. Have ever taken any medications for osteoporosis? (such as Fosamax,Boniva,Actonel,Reclast, Didronel) ❑ ❑
    If yes, what, when and how long? _____

HEALTH HISTORY Do you have, or have you had any of the following? *Please mark if applicable.*

❑ Anemia	❑ Head or Neck Radiation Treatment	❑ Rheumatic Heart Disease
❑ Asthma	❑ Hepatitis, Liver Disease	❑ Rheumatism/Arthritis
❑ Cancer or Tumors	❑ High Blood Pressure	❑ Sinus Pain
❑ Chest Pain or Angina	❑ HIV-AIDS	❑ Stroke
❑ Diabetes	❑ Kidney Disease	❑ Surgically Placed Heart Valves
❑ Epilepsy/Convulsions	❑ Nervous Disorders	❑ Tuberculosis
❑ Excessive Bleeding	❑ Respiratory Disease	❑ Phen-Fen related heart problems
❑ Glaucoma	❑ Rheumatic Fever	❑ Osteoporosis

Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
If yes, what? _____

CONSENT

I hereby authorize and request the doctor(s) to perform necessary x-rays, photographs, prophylactic and surgical procedures for the treatment and/or prevention of oral disease and do whatever treatment that his/her judgment may dictate. I also authorize and request the administration of such medications, anesthesia, or anesthetics as may be deemed advisable by the doctor(s) after they have been explained to me so that my consent is informed. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I authorized the dentist to contact my physician(s) if medical consultation is necessary.

I authorize release of any information relating to my dental claim. I understand that I am responsible for all costs of any treatment. I authorize payment directly to the doctor(s) of the group insurance benefits otherwise payable to me.

I certify that the above history was carefully considered and complete information was given.

X_____ _____ _____ _____
Patient Signature (Or parent/guardian if patient is a minor) Date Reviewed By Date

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