

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:**

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

- | | |
|---|---|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Penicillin or other Antibiotics | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates, Sedatives, or sleeping pills | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other: _____ |

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** _____