## **Updated Health History**

Patient Name:	Birth date:	Birth date:			
1. Are you in good health? YES NO			2. Any change in your health in the past year?	YE	S NO
3. My Medical Doctor is (NAME)			Phone		
4. Have you had any serious illness or operation?	YES	NO	Explain:		
5. Have you had any abnormal bleeding with too	th extra	ction or	other surgery? YES NO		
6. Do you bruise easily? YES NO			7. Have you ever had a transfusion? YES NO		
8. MEDICINES YOU ARE TAKING:	VEC	NO	9. Are you <u>ALLERGIC</u> to any of the following		NO
Antibiotics Coumadin or other blood thinners		NO NO	Local anesthetics or numbing Penicillin or other antibiotic	YES YES	
Blood pressure medication		NO	Sulfa drugs	YES	NO
Digitalis or other heart drugs		NO	Barbiturates or sleeping pills	YES	
Nitroglycerine	YES	NO	Aspirin	YES	NO
Antihistamines		NO	Iodine	YES	NO
Insulin or other med for diabetes		NO	Codeine or other narcotic	YES	NO
Cortisone or steroids	YES	NO	Latex gloves	YES	NO
Oral contraceptives	YES	NO	Sedatives	YES	NO
Herbal Supplements	YES	NO	Alcohol	YES	NO
Vitamins	YES	NO	Narcotics	YES	NO
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Bisphosphonate drugs (Fosamax, Boni	va, Arec	lia, Act	tonel, Zometa) used in cancer &osteoporosis treatment	YES	NO
10. Please list drugs you are <u>ALLERGIC</u> to:					
11. Are you taking any medicines regularly?					
12. Do you now have or have you had in the past	any of	the foll	owing diseases or problems?		
AIDS		Kid	ney problems		
Asthma		Ost	eoporosis		
Cancer		Pac	emaker		
Chest pain on exertion		Rhe	eumatic fever		
Cold sores/fever blisters		Seiz	zures		
COPD		Shi	ngles		
Damaged heart valves		Sho	ortness of breath		
Diabetes		Slee	ep Apnea		
Diarrhea		Sm	oke cigarettes		
Dry mouth		Sno	pring		
Epilepsy		Stro	-		
Excessive bleeding		Swe	ollen ankles		
Frequent thirst		Swe	ollen lymph nodes		
GERD (Reflux Disease)		Syp	hilis		
Heart attack		Thr	ush		
Hepatitis		Thy	vroid problems		
Herpes		Tub	perculosis		
Other sexually transmitted disease		Yea	ast infections		
High blood pressure		Imp	plants or replacements?		
Hives or rash			Breast		
HIV positive		-	_ _Joint (knee or hip)		
			Dental		
			Chin		
			Other		

## WOMEN

- Pregnant at this time
- \_\_\_\_Nursing at this time
- \_\_\_\_Menstrual problems
- \_\_\_\_Menopause

## **OTHER**

Anything else we should know about?

I have read all the information on this sheet and have completed the answers. I affirm that this information is correct to the best of my knowledge and that I will inform my dentist of any changes in my health history and medicines prescribed to me. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date