HEALTH HISTORY UPDATE

Name: ______________________________ Birthdate: ______________

Physician's Name: ____________________ Date of Last Visit: __________

DENTAL HISTORY

Reason for Today's Visit____ General Dentist______________

Date of Last Dental Care____________________________ Date of Last Dental Xrays________________

Check if you have had problems with any of the following:

- ○ Bad Breath
- ○ Food Collection Between teeth
- ○ Sensitivity to Cold/Hot
- ○ Bleeding Gums
- ○ Grinding Teeth
- ○ Sensitivity to Sweets
- ○ Clicking or Popping of Jaw
- ○ Periodontal Treatment
- ○ Sensitivity When Biting

Pharmacy Name/Location: ________________________________ Phone: ___________________

MEDICAL HISTORY

Have you ever been hospitalized or had a major operation? □ Yes □ No **If yes please explain:** _______________________

Have you ever had a serious head or neck injury? □ Yes □ No

Are you taking any medications, pills or drugs? □ Yes □ No **If yes, please list meds:**

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Do you take, or have you taken Phen Fen or Redux? □ Yes □ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □ Yes □ No

Are you on a special diet? □ Yes □ No **Do you use** Tobacco? □ Yes □ No Do you use controlled substances? □ Yes □ No

Do you wear contact lenses? □ Yes □ No

Women: Pregnant/Trying to get pregnant? □ Yes □ No Nursing? □ Yes □ No
Taking Oral Contraceptives pills? □ Yes □ No

ALLERGIES –CIRCLE ALL THAT APPLY:

Aspirin Penicillin Antibiotic Codeine Sulfa Sedatives Latex Local Anesthetics

Other, Please Explain: ____

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

AIDS/HIV	□ Yes	□ No	Cold Sores	□ Yes	□ No	Irregular Heartbeat	□ Yes	□ No
Allergies / Hay Fever	□ Yes	□ No	Congenital Heart Disorder	□ Yes	□ No	Kidney Problems	□ Yes	□ No
Alzheimer's Disease	□ Yes	□ No	Convulsions	□ Yes	□ No	Leukemia	□ Yes	□ No
Anaphylaxis	□ Yes	□ No	Cortisone Medicine	□ Yes	□ No	Liver Disease	□ Yes	□ No
Anemia	□ Yes	□ No	Diabetes	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No
Angina	□ Yes	□ No	Drug Addiction	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No
Arthritis/Gout	□ Yes	□ No	Emphysema	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Radiation Treatments	□ Yes	□ No
Artificial Joints	□ Yes	□ No	Excessive Bleeding	□ Yes	□ No	Renal Dialysis	□ Yes	□ No
Asthma	□ Yes	□ No	Fainting Spells/Dizziness	□ Yes	□ No	Shingles	□ Yes	□ No
Blood Disease	□ Yes	□ No	Frequent Cough	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Breathing Problem	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Stomach/Intestinal Diseas	□ Yes	□ No
Bruise Easily	□ Yes	□ No	Heart Attack/Failure	□ Yes	□ No	Stroke	□ Yes	□ No
Cancer	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Chemotherapy	□ Yes	□ No	Hepatitis Type_________	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Chest Pains	□ Yes	□ No	Hives or Rash	□ Yes	□ No			

Comments:____

_________________________________ _________________________________

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**