Thank You For Updating Your Health History

Patient's Name _____ Today's Date _____

Home Address _____ City _____ Zip _____

Home Phone Number _____ Your Birthdate _____ SSN _____

MEDICAL HEALTH HISTORY . . . AGE _____ PHONE NUMBER WHERE YOU CAN BE REACHED _____

General Health (Please Check): _____ Excellent _____ Good _____ Fair _____ Poor

1. Have you been a patient in the hospital during the past two years? What for? _____ YES NO
2. Have you been under the care of a medical doctor during the past two years? What for? _____ YES NO
3. Are you taking any medicine now? What? _____ YES NO

   _____
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? _____ YES NO
5. Have you ever had any excessive bleeding requiring special treatment? _____ YES NO
6. Have you been told you need Antibiotics before dental treatment? _____ YES NO
7. Circle any of the following which you have had or have at present:

Allergies or Hives	Congenital Heart Lesions	Heart Murmur	Pain in Jaw Joints
Alcoholism	Cortisone Medicine	Heart Pacemaker	Psychiatric Treatment
Anemia	Diabetes	Heart Surgery	Radiation Treatment
Angina Pectoris	Drug Addiction	Hearing Problems	Rheumatoid Arthritis
Arthritis	Emphysema	Hemophilia	Sickle Cell Disease
Artificial Heart Valve	Epilepsy or Seizures	Hepatitis A (infectious)	Sinus Trouble
Artificial Joint	Fainting or Dizzy Spells	Hepatitis B (serum)	Stress
Asthma	Genital Herpes	Hepatitis C	Stroke
AIDS	Glaucoma	High Blood Pressure	Thyroid Disease
Blood Transfusion	Hay Fever	Kidney Trouble	Tuberculosis (TB)
Bruise Easily	Headaches or Migraine	Latex Allergy	Ulcers
Chemotherapy (Cancer, Leukemia)	Heart Disease or Attack	Liver Disease	Yellow Jaundice
Cold Sores	Heart Failure	Nervousness	

Name of Physician: _____ Location (City) _____

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? _____ YES NO
9. Had your medical doctor ever said you have a cancer or tumor? _____ YES NO
10. Do you have any disease, condition, or problem not listed? _____ YES NO
11. Do you consume alcohol? _____ Occasionally _____ Moderate _____ More YES NO
12. Do you smoke? _____ YES _____ NO _____ Chewing Tobacco? _____ YES NO
13. WOMEN: Are you pregnant now? _____ YES NO

    Are you taking birth control pills? _____ YES NO

    Do you anticipate becoming pregnant? _____ YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Signature _____

DENTAL

1. If you could, what would you change about your smile? _____
2. Would you be interested in easily whitening your teeth? _____
3. What would you like your teeth to be like in 20 years? _____
4. How often do you: _____ Brush Daily? _____ How many days a week do you floss? _____ Do you use a water pic? _____
5. Do you feel you have mouth odor? _____
6. How often do you have your teeth and gums cleaned? Every _____ months.

FINANCIAL POLICIES . . .

Please review our financial arrangement information sheet. Out office wants all our patients to be able to comfortably afford dental care.