

Update Health History

Patient Name: _____

Birth date: _____

1. Are you in good health? YES NO 2. Any change in your health in the past year? YES 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 tooth extraction 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:

Antibiotics	YES	NO
Coumadin or other blood thinners	YES	NO
Blood pressure medication	YES	NO
Digitalis or other heart drugs	YES	NO
Nitroglycerine	YES	NO
Antihistamines	YES	NO
Insulin or other med for diabetes	YES	NO
Cortisone or steroids	YES	NO
Oral contraceptives	YES	NO
Vitamins	YES	NO
Herbal Supplements	YES	NO

9. Are you ALLERGIC to any of the following?

Local anesthetics or numbing	YES	NO
Penicillin	YES	NO
Sulfa drugs	YES	NO
Barbiturates or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotic	YES	NO
Latex gloves	YES	NO
Other _____		

Bisphosphonate drugs (Fosamax, Boniva, Aredia, Actonel, Zometa) **used in cancer and osteoporosis treatment.** YES NO

10. Please list drugs you are ALLERGIC to: _____

11. Please list any **medicines** taken regularly: _____

12. Do you now have or have you had in the past any of the following diseases or problems?

- | | |
|--|--|
| <input type="checkbox"/> ALLERGIC to other things: _____ | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent thirst |
| <input type="checkbox"/> Hives or rash | <input type="checkbox"/> Any implants? |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Joint (knee or hip) |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Chin |
| <input type="checkbox"/> Other sexually transmitted diseases | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GERD (Reflux Disease) | <input type="checkbox"/> Smoke cigarettes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Chest pain on exertion | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Do your ankles swell? | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Sleep Apnea | |

OTHER

Anything else we should know about? _____

WOMEN

- Pregnant at this time
- Nursing at this time
- Menstrual problems
- Menopause

I have read all of the information on this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge.

Signature

Date