Updated Health History Form

PLEASE PRINT OUT THIS FORM AND BRING IT WITH YOU COMPLETELY FILLED OUT.

Name:_____Phone:_____
Full Address:_____
Place of Employment:_____Phone:_____
Name of Dental Insurance Co.:_____

CIRCLE YOUR ANSWER:

1. Has there been any change in your health since your last visit?.....Yes No
Explain:_____

2. Are you allergic to any medication?.....Yes No
Explain:_____

3. Are you taking any medication?.....Yes No
Explain:_____

4. Are you pregnant, breast feeding or trying to get pregnant?.....Yes No
Explain:_____

5. Have you ever been told you have a heart murmur or mitral valve prolapse?..Yes No
If yes, have you taken your antibiotics today?.....Yes No

6. Are you having any specific dental problems at this time?.....Yes No
Explain:_____

7. Please circle any conditions that apply to you in any way:

Heart Attack
Hypoglycemia
High Blood Pressure
Birth Control Pills
HIV Positive
Sensitive Teeth
Tuberculosis/TB
Artificial Joints
Low Blood Pressure
Latex Sensitivity
Diabetic
Asthma
Hepatitis/Jaundice
Venereal Disease
Bladder or Kidney
Blood Thinner
Lung Disease
Rheumatic Fever
Angina
Snoring
Herpes
Epilepsy/Seizures
Aids
Tobacco Use
Hemophilia
Stroke
Any Other?_____

_____ _____
Signature Date

_____ _____
Reviewed By BP