Annual Health History Update

Patient Info:

Full Name_____ Date of Birth_____

Mailing Address_____City_____State_____Zip_____
Home Phone_____ Cell Phone_____ Email_____

Has your insurance changed? Yes or No. If yes, insurance name_____

Medical History:

Cardiovascular:
- ☐Angina (chest pain)
- ☐Artificial Heart Valve
- ☐Heart Conditions
- ☐Heart Surgery
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Mitral Valve Prolapse
- ☐Pacemaker
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Stroke

Cancer-Type:_____
- ☐Chemotherapy
- ☐Radiation

Endocrinology:
- ☐Diabetes
- ☐Hepatitis A/B/C
- ☐Jaundice
- ☐Kidney Disease
- ☐Liver Disease
- ☐Thyroid Disease

Gastrointestinal:
- ☐GERD
- ☐Ulcers (Stomach)

Viral Infections:
- ☐AIDS
- ☐HIV Positive
- ☐HPV

Respiratory:
- ☐Asthma
- ☐Emphysema
- ☐Respiratory Problems
- ☐Sinus Problems
- ☐Sleep Apnea
- ☐Tuberculosis

Hematologic/Lymphatic:
- ☐Anemia
- ☐Blood Disorders
- ☐Bruise Easily
- ☐Excessive Bleeding
- ☐Pregnant
- ☐Nursing

Musculoskeletal:
- ☐Arthritis
- ☐Artificial Joint
- ☐Jaw Joint Pain
- ☐Rheumatoid Arthritis

Neurological:
- ☐Anxiety
- ☐Depression
- ☐Dizziness
- ☐Drug/Alcohol
- ☐Fainting
- ☐Seizures
- ☐Psychiatric Illness

Are you under the care of a physician? Y or N, if yes, please provide physician & phone #_____

Have you had a serious illness, operation or hospitalization in the past 5 years? Y or N, if yes, please explain_____

Have you ever had surgery? If so, please explain_____

Please list all Medications, Vitamins, and Supplements:	**ALLERGIES: Please list all medications or substitutes you are allergic to:**	**Have you ever in the past, or are you currently taking any medication for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications:**

Consent:

The undersigned hereby authorizes Doctors to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I have read, understood and agreed to the above terms and conditions.

_____ _____ _____

Signature of patient/Legal guardian Date Dentist Signature