PATIENT INFORMATION & HEALTH HISTORY UPDATE

Patient:_____ **Date:**_____

Address:_____ **City & Zip Code**_____

Home Phone#_____ **Cell**_____ **Work**_____

E-mail address_____

Primary Care Physician _____ **Ph#**_____

1. Since your last visit to our office, **have there been any changes in your health**? Yes___ No___
   If yes, please explain _____
   _____
2. **Have you recently required other health services** or visited your regular doctor? Yes___ No___
   If yes, please explain_____
   _____
3. **Have you been hospitalized** since your last dental visit? Yes___ No___
   If yes, please explain_____
   _____
4. **Do you have Hepatitis?** Yes __ No ___ **Have you tested positive for HIV/AIDS?** Yes__No___
5. WOMEN only: Are you pregnant? Yes___ No ___ If yes, due date: _____
6. Have you been diagnosed with **any condition requiring an antibiotic** before dental treatment? Yes ___ No ___
7. **Please list any drug allergies:**
   _____
   _____
   _____
8. **Please list any medications** (both over-the-counter products, diet and herbal supplements, and prescription drugs) that you are currently taking, reason for taking them, and their dosages:

Drug/Reason Taken:	**Dosage:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Signature:_____**Date:**_____
Date Reviewed/Reviewer's Name _____

Patient's Signature:_____**Date:**_____
Date Reviewed/Reviewer's Name _____

Patient's Signature:_____**Date:**_____
Date Reviewed/Reviewer's Name _____