HEALTH UPDATE: ALL INFORMATION IS STRICTLY CONFIDENTIAL

NAME _____ Today's Date _____

Email _____ DATE OF BIRTH _____ AGE _____

	Please check (☑) Yes	No
Are you allergic to or have had an adverse reaction to any medications or injections?	❑	❑
If yes, please specify: _____		
Are you allergic to or have had an adverse reaction to latex/rubber products or to any foods?	❑	❑
If yes, please specify: _____		
Are you taking any prescription or non-prescription medications?	❑	❑
If yes, please list names, dosages & condition: _____		
_____		
_____		
Do you smoke?	❑	❑
If yes, how much? _____		
Women: Are you pregnant or nursing?	❑	❑
If pregnant, what is the expected delivery date? _____		
1. Have you had any immunocompromising condition or treatment such as leukemia or chemotherapy?	❑	❑
2. Do you have a heart murmur or mitral valve prolapse?	❑	❑
3. Have you ever had rheumatic fever or infective endocarditis?	❑	❑
4. Do you have a pacemaker or prosthetic heart valve?	❑	❑
5. Do you have a prosthetic or artificial joint?	❑	❑
6. Do you have a bleeding problem or disorder or any heart or blood pressure problems?	❑	❑

If you answered yes to any of questions 1-6 above, please give details: _____

_____

Do you have or have you ever had any of the following? **Please check (☑)**

❑asthma ❑stroke ❑heart attack ❑angina ❑arthritis ❑diabetes
❑mental/nervous disorder ❑stomach ulcers ❑kidney disease ❑drug/alcohol dependency ❑organ transplant
❑memory issues ❑ Alzheimer's/dementia ❑cancer ❑ herpes/cold sores ❑HIV

If you checked any of the boxes above, please give details: _____

_____

Please list past hospitalizations and serious illnesses or conditions: _____

_____

Is there anything else about yourself that the dentist should be made aware of?_____

_____

Emergency contact name & phone:

Physicians name & phone:

SIGNATURE (Patient) _____

Dentist's Notes: