HEALTH HISTORY UPDATE

Name:________________________________ DOB:______________ Today's Date:___________

Address:_________________________________ City:___________________ State:_________

Home Phone:________________________ Cell:_________________________

1. Have there been any changes in your health since your last visit?

   ____

   ____

2. Physician's name:____
3. Have you been hospitalized since your last visit?______________________________

   If yes, nature of problem:____
4. Any new illnesses?____

   ____
5. Are you currently taking any medication(s)?______________________________

   To treat:____

   Name(s) and dosage(s):____

   ____
6. Do you have any allergies or reactions to any medications or drugs?

   ____
7. Women only: Are you pregnant?______________ If yes, due date:___________________
8. Are you having any concerns about your teeth?_____________________________
9. Current Insurance Carrier:____________________________ ID:____________________

Patient Signature:____

Doctor Signature:____