Annual Health History Update

Have there been any health history changes or address in the last year? If yes, please explain:

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Are you currently taking any medication ? If yes, please list:

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Do you currently or have you ever had any of the following conditions? Please **Circle** as it applies:

Heart Trouble	Hepatitis A (infection)	Asthma
Heart Attack	Hepatitis B (serum)	Emphysema
Open-Heart Surgery	Hepatitis C	Autoimmune Disease
Tuberculosis (TB)	Liver Disease	Multiple Sclerosis
Heart Pacemaker	Kidney Disease	Shortness of Breath
Artificial Heart Valve	Bleeding Disorder	Sinus Trouble
Mitral Valve Prolapse	Anemia	Head/Neck Injury
Congenital Heart Defect	HIV	Gout
Rheumatic Fever	AIDS	Arthritis
Rheumatic Heart Failure	Drug Addiction	Seasonal Allergies
Angina (chest pain)	Alcoholism	Steroid Therapy
Congestive Heart Failure	Diabetes	Glaucoma
Swollen Ankles	Ulcers	Tumors/Growths
High Blood Pressure	Fainting Spells	Cancers
Low Blood Pressure	Epilepsy/Seizures	Chemo/Radiation
Artificial Joint/Implant	Stroke	Organ Transplant
Thyroid Problem	Sexually Transmitted Disease	Marked Weight Change

Are you currently having any dental concerns that you would like addressed today?
If yes, please explain:

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Are you currently interested in having a better smile?
If yes, please explain:

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This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Print Patient Name: ____

Patient Signature: (or parent if minor) ________________________________Date: __________

Doctor Signature: ____Date:__________