**Dr. Alan R. Levine and Dr. Nadine L. Vaughan**

**UPDATED HEALTH HISTORY**

**(Please print all Information)**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Name: M F Date of Birth**

**Mr. Mrs. Ms. Miss Dr. (Circle one)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address City State Zip Code**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address Home Phone Number**

(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone Number Work Phone Number**

**Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Self/ Spouse/Parent)**

**Social Security** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name / Phone Number /Location** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who may we contact in case of an emergency and their phone number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT ALLERGIES (IF ANY) LIST OF MEDICATIONS & DOSAGE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2017

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE THE FOLLOWING (YES/NO):**

NO YES Has there been any changes in your general health this year \_\_\_\_\_Explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO YES Are you now under a physician’s care:

**Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NO YES Have you Been Hospitalized or had a serious illness in the past five years?

NO YES Are you Pregnant?

**HAVE YOU TAKEN THE FOLLOWING MEDICATIONS IN THE PAST SIX MONTHS (YES/NO)**:

NO YES Anticoagulants (Blood Thinners) NO YES Insulin or Pill for Diabetes/Other

NO YES Blood Pressure Medication NO YES Digitalis or Medication for Heart condition

NO YES Diuretics (Water Pill) NO YES Nitroglycerine

NO YES Steroids (e.g. Prednisone, Cortisone) NO YES Birth Control Pills

NO YES Tranquilizers (e.g. Valium, Librium) NO YES Dilantin

NO YES Antidepressants (e.g. Prozac, Zoloft) NO YES Aspirin or Anti-inflammatory medications

**HAVE YOU HAD AN ALLERGIC REACTIONTO T FOLLOWING (YES/NO):**

NO YES Dental Anesthetics NO YES Sulfa drugs

NO YES Penicillin or other antibiotics NO YES Food\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO YES Codeine or other narcotics NO YES Latex Gloves

NO YES Aspirin or other anti-inflammatory medications NO YES Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (YES/NO):**

NO YES Blood disorders, anemia or leukemia NO YES Congenital heart defects

NO YES Bleeding disorders NO YES Mitral valve prolapse

NO YES Stomach ulcers NO YES Rheumatic heart disease/ fever

NO YES Colitis NO YES Heart murmur

NO YES Kidney trouble or renal dialysis NO YES Heart condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO YES Hepatitis, jaundice, or liver disease NO YES Heart attack

NO YES Tuberculosis NO YES High Blood Pressure

NO YES Tested Positive for HIV NO YES Pacemaker

NO YES Active venereal disease NO YES Artificial heart valve

NO YES Psychiatric therapy NO YES Stroke

NO YES Treatment for substance abuse NO YES Arthritis

NO YES Sleep Disorders NO YES Artificial /replacement, Bones/joints

NO YES Thyroid disease NO YES Epilepsy

NO YES Diabetes NO YES Asthma

NO YES Cancer NO YES Blood Transfusion

NO YES Surgery or radiation treatment for NO YES Have you ever been denied permission

a tumor, growth, or other condition to give blood.

**HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING (YES/NO):**

NO YES Chest pains after mild exercise NO YES Frequent urination

NO YES persistent cough or coughing up blood NO YES Excessive thirst

Do you have any other disabilities that we should consider in planning your dental treatment? Yes /No

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke Yes/ No What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much? \_\_\_\_\_\_\_\_\_\_\_\_ How Many Years? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Use Smokeless Tobacco Products? \_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_

Do you Drink Alcoholic beverages? \_\_\_\_\_\_\_\_\_\_\_\_\_ How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_