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**_____

Employer of Subscriber _____

(Self/ Spouse/Parent)

Social Security #_____ **Insurance ID#**_____ **DOB of Subscriber**_____

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**

_____ _____

_____ _____

_____ _____

_____ _____

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 Blood Pressure Medication
NO YES Diuretics (Water Pill)
NO YES Steroids (e.g. Prednisone, Cortisone)
NO YES Tranquilizers (e.g. Valium, Librium)
NO YES Antidepressants (e.g. Prozac, Zoloft)
NO YES Insulin or Pill for Diabetes/Other
NO YES Digitalis or Medication for Heart condition
NO YES Nitroglycerine
NO YES Birth Control Pills
NO YES Dilantin
NO YES Aspirin or Anti-inflammatory medications

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

NO YES Dental Anesthetics
NO YES Penicillin or other antibiotics
NO YES Codeine or other narcotics
NO YES Aspirin or other anti-inflammatory medications
NO YES Sulfa drugs
NO YES Food_____
NO YES Latex Gloves
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 Bleeding disorders
NO YES Stomach ulcers
NO YES Colitis
NO YES Kidney trouble or renal dialysis
NO YES Hepatitis, jaundice, or liver disease
NO YES Tuberculosis
NO YES Tested Positive for HIV
NO YES Active venereal disease
NO YES Psychiatric therapy
NO YES Treatment for substance abuse
NO YES Sleep Disorders
NO YES Thyroid disease
NO YES Diabetes
NO YES Cancer
NO YES Surgery or radiation treatment for a tumor, growth, or other condition
NO YES Congenital heart defects
NO YES Mitral valve prolapse
NO YES Rheumatic heart disease/ fever
NO YES Heart murmur
NO YES Heart condition_____
NO YES Heart attack
NO YES High Blood Pressure
NO YES Pacemaker
NO YES Artificial heart valve
NO YES Stroke
NO YES Arthritis
NO YES Artificial /replacement, Bones/joints
NO YES Epilepsy
NO YES Asthma
NO YES Blood Transfusion
NO YES Have you ever been denied permission to give blood.

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

NO YES Chest pains after mild exercise
NO YES persistent cough or coughing up blood
NO YES Frequent urination
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?
_____you Drink Alcoholic beverages? _____ How much daily? _____