**HEALTH HISTORY UPDATE**

Patient:___________________________________ Date: _______________________________

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

_______________________________________________________________________________

_______________________________________________________________________________

2. Have you recently required other health services?_______________________________
   If yes, nature of care:_______________________________________________________

3. Physician's name:_________________________________________________________

4. Have you been hospitalized since your last visit?________________________________
   If yes, nature of problem:____________________________________________________

5. Any new illnesses?

   _________________________________________________________________________

   _________________________________________________________________________

6. Are you taking any medication(s) now?_________________________________________
   To treat: ________________________________________________________________
   Name & Dosage: __________________________________________________________

7. Do you have any new allergies or reactions to medications or drugs?

______________________________________________________________________________

8. Women only: Are you pregnant?___________ If yes, due date:_____________________

9. Any other new diseases, medications or problems you think we should know about?

_______________________________________________________________________________

_______________________________________________________________________________

Patient signature: _________________________________________________________

Doctor signature: __________________________________________________________