

HORTON D.D.S. VRANAS

Office Use: _____

Patient Information & Health History Update

Patient Name: _____
Last, First MI (Preferred Name)
Phone- Home: _____ Work: _____ Cell: _____
E-Mail: _____
Address: _____
Street City Zip Code
Preferred Method of Confirming: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|----------------------------------------------------|--------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Cocainé Use | <input type="checkbox"/> Measles/Mumps |
| Place/Date: _____ | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Mononucleosis |
| Type _____ | <input type="checkbox"/> Cardiac Stent/Year ____ | <input type="checkbox"/> Cortisone Treatments | Allergies |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Amoxicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Seizures | <input type="checkbox"/> Aspirin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Codeine Allergy |
| Type _____ Year _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Dental Anesthetics |
| Chemo _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Latex Allergy |
| Radiation _____ | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes Diet Controlled_ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tetracycline Allergy |
| Insulin Dependant _____ | <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Ulcer(s) | <input type="checkbox"/> Sulfa Drug Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other Drug Allergies |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Blood Disease | | |

Do you smoke? Yes ___ No ___ How many per day? ___ Do you use chewing tobacco? Yes ___ No ___

Are you or have you ever taken Bisphosphonate therapy drugs: ie: Actonel, Boniva, Fosamax or Didronel for osteoporosis or certain types of cancer? Yes ___ No ___ Medication Name & Start Date: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Have you ever had a blood transfusion? No ___ Yes ___ What year? _____

Have you had any recent serious illness or surgery? _____

Are you pregnant? No / Yes What week? ___ Are you nursing No / Yes Are you taking birth control pills? No / Yes

Are you currently taking any medications, including over-the-counter, ie: Aspirin, Advil, Herbs or Vitamins? No/Yes

List Medications & Reason for Taking:

It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and/or treatment.

Date: _____

Signature of patient, parent or guardian