CACTUS HORIZON
DENTISTRY

Health History Update

Name:_____ **DOB:**_____ **Todays Date:**_____

Have you had, or do you currently have?	YES	NO	NOTES
1. Rheumatic fever?			
2. Damaged heart valves/ mitral valve prolapse?			
3. Heart murmur?			
4. High blood pressure?			
5. Low blood pressure?			
6. Chest pain/angina?			
7. Heart attack(s)?			
8. Irregular heart beat?			
9. Cardiac pacemaker?			
10. Heart surgery?			
11. Pneumonia, bronchitis, chronic cough?			
12. Asthma?			
13. Hay fever/sinus problems?			
14. Snoring/sleep apnea?			
15. Difficult breathing/other lung trouble?			
16. Tuberculosis?			
17. Emphysema?			
18. Do you smoke? If so, number of packs per day? _____			
19. Do you use chewing tobacco?			
20. Blood transfusion?			
21. Blood disorder such as anemia?			
22. Bruise easily?			
23. Bleeding tendency/abnormal bleed?			
24. Hepatitis, jaundice, or liver disease?			
25. Infections mononucleosis?			
26. Gallbladder trouble?			
27. Fainting spells?			

Have you had, or do you currently have?	YES	NO	NOTES
28. Convulsions/epilepsy?			
29. Stroke			
30. Thyroid trouble?			
31. Diabetes?			
32. Low blood sugar?			
33. Kidney trouble?			
34. High cholesterol?			
35. Are you on dialysis?			
36. Swollen ankles/arthritis/joint disease?			
37. Osteoporosis/osteopenia?			
38. Osteonecrosis?			
39. Stomach ulcers/acid reflux?			
40. Contagious diseases?			
41. Sexually transmitted diseases?			
42. Problems with immune system? Possibly from medication/surgery, etc.			
43. Delay in healing?			
44. A tumor or growth?			
45. Cancer/radiation therapy/ chemotherapy?			
46. Chronic fatigue/night sweats?			
47. Are you on a diet?			
48. A history of alcohol abuse?			
49. A history of drug abuse?			
50. Contact lenses?			
51. Eye disease/glaucoma?			
52. Mental health problems/anxiety/ depression?			
53. A removable dental appliance?			
54. Pain or clicking of the jaws when eating?			

Are you now taking?	YES	NO	NOTES
55. Any kind of medication, drug, pills?			
56. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish Oil?			
57. Have you ever taken diet pills?			
58. Any natural product, herbal supplement or homeopathic remedy?			
59. Are you taking, or have you ever taken, bone density meds. or bisphosphonates suck as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, or Reclast in the past 12 years?			
60. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? Is so, please list:			
61. Please list any medications you are currently taking: Medication I Dosage I Frequency			

Are you allergic to, or had a reaction to?	YES	NO	NOTES
62. Local anesthetic (numbing meds.)?			
63. Penicillin?			
64. Other antibiotics?			
65. Sulfa drugs?			
66. Sodium pentothal/Valium/ other tranquilizers?			
67. Aspirin?			
68. Amoxicillin?			
69. Codeine or other narcotics?			
70. Other medications?			
71. Latex?			
72. Soy?			
73. Eggs/yolk?			
74. Sulfites?			
75. Do you have any known allergies?			
76. Please list any allergies other than drug allergies:			

Is there a family history of:

☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problem

	Yes	No
1. Have there been any change in your general health in the past year?	☐	☐
2. Are you under the care of a physician?	☐	☐
3. Have you had any operations or been hospitalized in the past five years?	☐	☐

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answer to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that i have made in the completion of this form.

X_____ **X**_____

Signature of patient (Parent or Guardian if Minor) **Date**

FOR OFFICE USE ONLY

X_____ **X**_____

Reviewed by **Date**