Vibrant DENTAL
the confident smile specialists

HEALTH HISTORY UPDATE

Patient Name: ____________________ Date of Birth: __________

Home Address: ____________________

City: __________ State: __________ Zip: __________

Cell #: __________ Home #: __________ Work #: __________

Email: ____________________

Primary Physician/Clinic ____________________ Phone: __________

Date of last Physical Exam: ____________________

Past Medical History

Artificial Implants or Joints (hip, knee,etc)	Bleeding Disorders,Hemophilia	Radiation/Chemotherapy
Heart conditions (surgery, disease, attack)	Blood Transfusions	Arthritis/Rheumatism
Congenital Heart Disease	AIDS/HIV Positive	Kidney Disorders
Heart Murmur, Mitral valve prolapse	Hepatitis A, B or C	Liver Disease
High Blood Pressure	History of Alcohol/Drug Abuse	Thyroid Disorders
Heart Pacemaker or Defibrillator	Psychiatric/Psychological Care	Diabetes
Rheumatic Fever or heart disease	Nervous/Anxious	Emphysema
Stroke	Neurological Disorders	Asthma
Sleep Apnea	Epilepsy or Seizures	Tuberculosis

Current / Recent Symptoms (please circle)

Cold Sores	Chest Pain	
Night Sweats	Swollen Ankles	Sinus problems
Chronic Cough	Numbness	Bleeding/Bruising
Fainting/Dizzy Spells	Shortness of Breath	Headaches

Explain any circled answers above and list any disease or condition not listed:____________________

____

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Allergies (medications, latex, local anesthetic, food, metals, ect**)**____________________

____

Current medications (reason**):**____________________

____

____

Are you currently taking blood thinners or anti-coagulants? e.g.: Aspirin, Coumadin, Plavix, Heparin Yes / No

If yes, please list date and quantity of last dose: ____________________

Are you pregnant? Yes - _____ Months / No Are you nursing? Yes / No

Do you **Smoke** / **Chew** Tobacco? Yes / No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you may contact my health care provider who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian signature ____________________ Date: __________