Patient Health Record Update

Patient Name: Last ______________________________ First ___________________________ Middle ____

Home Address ____

City ______________________________ State _____ Zip ________ Date of Birth ____________________

Home # ______________________ Work # _______________________ Cell # ______________________

Correspondence by email: ☐ YES ☐ NO E-mail ____

Employer ____ Change of Insurance ☐ YES ☐ NO

Physician's Name _______________________________________ Phone ________________________

Are you under a physician's care now? ☐ YES ☐ NO

If **YES**, reason ____

Contact in Case of Emergency: _______________________ Phone: ____________ Relation: __________

List any medications you are currently taking (if none, please print none)

MEDICATIONS	REASON FOR TAKING

Are you allergic to any of the following? Please check those that apply.

☐ Aspirin	☐ Latex	☐ Sulfa
☐ Codeine	☐ Local Injected Anesthetic	☐ Other Drugs
☐ Iodine	☐ Penicillin	☐ Nuts

If other, please list ____

Do you bleed easily? ☐ YES ☐ NO

Have you ever had radiation therapy? ☐ YES ☐ NO

Are you taking any Bisphosphonates? ☐ YES ☐ NO If yes, how long? _____________________

(Examples: Fosamax, Boniva, Actonel, Zometa)

Women, are you pregnant? ☐ YES ☐ NO

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

☐ AIDS			☐ Hepatitis
☐ Asthma	Heart Problems		☐ Herpes
☐ Blood Disorder	☐ Angina	☐ Heart Murmur	☐ High Blood Pressure
☐ Cancer	☐ Bypass Surgery	☐ Mech Heart Valve	☐ Prosth Joint Replacement
Type ____________	Date ____________	☐ Mitral Valve Prolapse	Type ________________
Date ____________	☐ Congenital Heart Def	☐ Open Heart Surgery	Date ________________
☐ Diabetes	☐ Coronary Angioplasty	Date ____________	☐ Stroke
☐ Dialysis Shunt	☐ Heart Attack	☐ Pacemaker	☐ Thyroid Trouble
☐ Epilepsy	Date _____________	Date placed ________	☐ Tobacco Use
☐ Glaucoma	☐ Other ____________________________________		☐ Tuberculosis
☐ Hearing Loss			☐ Venereal Disease
☐ Liver Disease	☐ Other ____________________________________		

SIGNATURE ____ **DATE** ____________