River City Dentistry, PC (Jason Allred, DMD)

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Health History Update

Have you been under the care of a physician in the past year? ◯ Yes ◯ No

If yes, what for, and what is the name of your medical doctor?

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Have had any surgery or been a patient in a hospital during the last year? ◯ Yes ◯ No

If yes, please describe.

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Premed ◯ Yes ◯ No

Name of Premed ____________________

Are you currently taking medications, including vitamins, OTC medications, ect?

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Have you ever taken any Bisphosphonates (Boniva, Reclast, Fosamax, Actonel, Zometa) ◯ Yes ◯ No

If yes, please explain

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Blood Pressure ______________________

A1C Level ______________________

Have you experienced any of the following:

- [ ] Allergies
- [ ] Hives
- [ ] Blood Disease
- [ ] Anemia
- [ ] Sickle Cell Disease
- [ ] Hemophilia
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Failure/Attack
- [ ] Mitral Valve Prolapse
- [ ] High Blood Pressure
- [ ] Blood Transfusion
- [ ] Excessive Bleeding
- [ ] Angina Pectoris
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Hepatitis
- [ ] Respiratory Problems
- [ ] Asthma
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Stomach Problems
- [ ] Ulcers
- [ ] Cancer
- [ ] Radiation/Chemotherapy
- [ ] Tumors
- [ ] Heart Surgery
- [ ] Pacemaker
- [ ] Aritificial Heart Valve
- [ ] Artificial Joints
- [ ] Arthritis
- [ ] Rheumatism
- [ ] Venereal Disease
- [ ] HIV/AIDS Positive
- [ ] Head Injuries
- [ ] Vertigo
- [ ] Fainting
- [ ] Nervous Disorders
- [ ] Epilepsy
- [ ] Diabetes
- [ ] Thyroid Problems
- [ ] Jaundice
- [ ] Glaucoma
- [ ] Drug Addiction
- [ ] Sinus Problems
- [ ] Chronic Cough
- [ ] Cold Sores/Blisters
- [ ] Other

Are you currently pregnant? ◯ Yes ◯ No

All known allergies

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Comments/additional notes

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Signature ______________________________ **Date** ____________

Response Date: ___________