MG
MARK GIVAN DDS

Health History Update

Patients Name_____Today's Date_____

Birthdate_____Phone Number_____Cell Number_____

Address_____

Dental History

Check if you have had problems with any of the following:

- ○ Bad breath
- ○ Bleeding gums
- ○ Clicking or popping jaw
- ○ Food collection between teeth
- ○ Grinding teeth
- ○ Loose teeth or broken filling
- ○ Sensitivity to cold/hot
- ○ Sensitivity when biting
- ○ Sores or growth in mouth

How often do you floss?_____How often do you brush?_____

Medical History

Physician's Name_____Date of last visit_____

Have you had any serious illnesses or operations?_____If yes, describe_____

Have you ever had a blood transfusion? Yes or No If yes, approx. date(s)_____

Are you pregnant? Yes or No Nursing? Yes or No Taking birth control? Yes or No

Check if you have or have had any of the following:

- ○ Anemia
- ○ Arthritis,Rheumatism
- ○ Artificial Heart Valve
- ○ Artificial Joints
- ○ Asthma
- ○ Blood Disease
- ○ Back Problems
- ○ Cancer
- ○ Chemical Dependency
- ○ Cortisone Treatments
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Headaches
- ○ Heart Murmur
- ○ Heart Disease
- ○ Hemophilia
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mitral Valve Prolapse
- ○ Pacemaker
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Rheumatic Fever
- ○ Snoring
- ○ Stomach Problems
- ○ Stroke
- ○ Swollen Ankles
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Tobacco Habit
- ○ Ulcers
- ○ Venereal Disease
- ○ Other_____

Medications

List current medications:_____

_____

Allergies (circle that apply)

Asprin Local Anesthetic Sulfa

Codeine Penicillin Latex

Signature of patient, parent or guardian_____Date_____

Doctor Signature_____Date_____