Health History Update

Patient First Name:_____

Patient Last Name:_____

Date of Birth:_____

Today's Date:_____

Any Health Changes?: Yes_____ No_____

If yes, please explain:

Any Allergies to Anesthetic?:_____

Any Medications presently taking?:_____

Any Allergies or Drug sensitivities?:_____

Any Blood Disorders or Heart Conditions?: Yes_____ No_____

If yes, please explain:

Patient/Parent/Guardian Signature: _____
(if patient is under 18yrs old, Parent/Guardian must sign)

Printed Name of Patient/Parent/Guardian:_____
(if patient is under 18yrs old, Parent/Guardian printed name)