HEALTH HISTORY UPDATE

PATIENT NAME ______________________________

DATE ______________________________

Are there any changes in your medical history? Yes (if so please list) No

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Recent Surgeries? Yes (if so please list) No

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Allergies: ______________________________

WE MUST HAVE A COMPLETE LIST OF ALL CURRENT MEDICATIONS EACH VISIT!

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Do you have a joint replacement or implant?	Yes	No
Are you Pregnant?	Yes	No
Do you have High Blood Pressure?	Yes	No
Do you take a Blood Thinner medication?	Yes	No
Do you have an artificial heart valve, a history of infective Endocarditis, a cardiac transplant or a congenital heart condition?	Yes	No
Do you Snore?	Yes	No
Do you have Sleep Apnea?	Yes	No
Do you wear a CPAP?	Yes	No

IN CASE OF EMERGENCY WHO MAY WE CONTACT?

NAME ______________________________

RELATIONSHIP ______________________________

PHONE ______________________________

PHYSICIAN'S NAME & PHONE NUMBER ______________________________

PATIENT'S SIGNATURE ______________________________

MARK ANY CHANGES OF:

ADDRESS ______________________________

PHONE ______________________________

INSURANCE ______________________________