HEALTH HISTORY UPDATE

Name: _____
Last First MI Title

Address: _____City: _____State: _____Zip:_____

Preferred Name: _____ ☐ Male ☐ Female DOB: _____

SS#:_____ Drive License: _____ E-mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about out office? _____

Emergency contact person and phone number: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

☐ YES	☐ NO	Cancer or tumor
☐ YES	☐ NO	Heart ailment or angina
☐ YES	☐ NO	Heart Murmur, mitral valve prolapse
		Heart defect
☐ YES	☐ NO	Rheumatic fever or rheumatic heart
		Disease
☐ YES	☐ NO	Artificial joint or valve
☐ YES	☐ NO	High or low blood pressure
☐ YES	☐ NO	Pacemaker
☐ YES	☐ NO	Tuberculosis or other lung problems
☐ YES	☐ NO	Kidney disease
☐ YES	☐ NO	Hepatitis or other liver disease
☐ YES	☐ NO	Alcoholism
☐ YES	☐ NO	Blood transfusion
☐ YES	☐ NO	Diabetes
☐ YES	☐ NO	Neurologic condition
☐ YES	☐ NO	Epilepsy, seizures, or fainting spells
☐ YES	☐ NO	Arthritis
☐ YES	☐ NO	Herpes or cold sores
☐ YES	☐ NO	AIDS or HIV positive
☐ YES	☐ NO	Migraine headaches or frequent
		Headaches
☐ YES	☐ NO	Anemia or blood disorders
☐ YES	☐ NO	Abnormal bleeding after extractions,
		Surgery, or trauma
☐ YES	☐ NO	Hayfever or sinus trouble
☐ YES	☐ NO	Allergies or hives
☐ YES	☐ NO	Asthma

Do you smoke or use chewing tobacco? ☐ YES ☐ NO

Are you allergic to, or have you reacted adversely to
Any of the following?

☐ YES	☐ NO	Latex materials
☐ YES	☐ NO	Penicillin or other antibiotics
☐ YES	☐ NO	Local anesthetics (“Novocain”)
☐ YES	☐ NO	Codeine or other narcotics
☐ YES	☐ NO	Sulfa drugs
☐ YES	☐ NO	Barbiturates, sedatives, or sleeping pills
☐ YES	☐ NO	Aspirin
☐ YES	☐ NO	Other:

_____

Are you taking any of the following

☐ YES	☐ NO	Aspirin
☐ YES	☐ NO	Anticoagulants (blood thinners)
☐ YES	☐ NO	Antibiotics or sulfa drugs
☐ YES	☐ NO	High blood pressure medicine
☐ YES	☐ NO	Antidepressants or tranquilizers
☐ YES	☐ NO	Insulin, Orinase, or other diabetes drug
☐ YES	☐ NO	Nitroglycerin
☐ YES	☐ NO	Cortisone or other steroids
☐ YES	☐ NO	Osteoporosis (bone density) medicine
☐ YES	☐ NO	Other:

_____

_____

Women:

☐ YES	☐ NO	May be pregnant
		Expected delivery date: _____
☐ YES	☐ NO	Taking hormones or contraceptives

Physician Name: _____ Physician Phone Number: _____

List any medication you are taking: _____

_____

Do you have any disease, condition, or problem not listed above? _____

_____

Please add anything else you would like us to know about your oral hygiene: _____

Signature of patient (or parent): _____ Date: _____

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