# HEALTH HISTORY UPDATE

Name: _____ _____ Gender _____
Last First MI Title Preferred Name
Address: _____ City: _____ State: _____ Zip:_____

DOB: _____ SS#:_____ Drive License: _____ E-mail_____

Home Phone: _____ Work Phone: _____ Cell Phone_____ Marital Status: _____

Have you had any changes on your Dental Insurance? Y/N Name: _____ ID#: _____ GP#: _____

Employer:_____ Occupation: _____

Emergency contact person and phone number: _____

Pharmacy: _____ 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 Asthma
☐ 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 Emotional distress

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 Sulfite or Bisulfite
☐ 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

Please list other medications you are taking:

_____

_____

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 emotional disability, disease, condition, or problem not listed above? _____

_____

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

☐ **The information above is correct to the best of my knowledge.**

☐ **I give consent to receive text messages through my phone concerning my dental appointments.**

☐ **I would like to receive a reminder of my appointment by:**

**Email Y / N** **Phone Call Y / N** **Texting Y / N** **Mobile # _____**

☐ **I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved.**

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

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