# Health History Update

## Established Patient – Dental and Medical Health History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Patient's First Name

Patient's Last Name

Patient's Date of Birth

Reason for today's visit:

Today's Date:

**Contact Information**

Cell Phone #

Home Phone #

Work Phone #

Email Address

Street Address 1

Street Address 2

Emergency Contact Name

Emergency Contact Phone Number

Emergency Contact Relationship to Patient

- ◯ Spouse
- ◯ Parent
- ◯ Child
- ◯ Friend

How would you like to be contacted?

- ☐ Text
- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ Email

Any Changes in Insurance?

- ◯ Yes
- ◯ No

Policy Holder Name

Subscriber ID #

Subscriber Date of Birth

Group Number

Relationship to subscriber

Any changes in dental health since your last visit?

- ◯ Yes
- ◯ No

If yes, please explain:

Any surgeries, hospitalizations, disease/condition diagnoses, or other changes in general (medical) health since last dental visit?

- ◯ Yes
- ◯ No

Do you have, or have you ever had, any of the following conditions?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem

- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Dizziness
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Hearing Impairment
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Trouble/Disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mitral Valve Prolapse
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Pondimin/Fen-Phen
- [ ] Psychiatric Care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sleep Apnea
- [ ] Spina Bifida
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] TMJ
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Vision Loss/Blindness
- [ ] Yellow Jaundice
- [ ] None of the Above

Are you taking any prescription medications?

- ◯ Yes
- ◯ No

If yes, please explain:

Have you ever taken medications (such as bisphosphonates) that affect bone or to prevent bone disease?

- ◯ Yes
- ◯ No

If yes, please explain:

Are you allergic to any of the following?

- [ ] Acrylics
- [ ] Antibiotics
- [ ] Aspirin
- [ ] Codeine
- [ ] Iodine
- [ ] Latex
- [ ] Local Anesthetics
- [ ] Metals
- [ ] Penicillin
- [ ] Sulfa drugs
- [ ] None of the Above
- [ ] Other

If other, please specify

Do you use any tobacco or marijuana products or other controlled substances?

- ◯ Yes
- ◯ No

If yes, please explain:

**For Women Only**

Are you pregnant?

◯ Yes ◯ No

Females only: Are you taking birth control?

◯ Yes ◯ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature Date of signing

*Date:*

**BELOW IS FOR OFFICE USE ONLY**

Provider's Signature Date of review

*Date:*