

**HEALTH HISTORY UPDATE**

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Address \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell : \_\_\_\_\_

We send appointment reminders by Email and Text; do you have text messaging on your cell phone? \_\_\_\_\_

**PLEASE NOTE: IF YOU DO NOT WANT TO RECEIVE TEXT MESSAGE REMINDERS OR YOU ARE CHARGED BY YOUR MOBILE PROVIDER PLEASE INFORM THE FRONT OFFICE.**

Email: \_\_\_\_\_

- 1. Name of your medical doctor \_\_\_\_\_
- 2. Are you under medical care now? Yes No For What? \_\_\_\_\_
- 3. Are you taking any medications? Yes No Please list \_\_\_\_\_
- 4. Are you taking recreational drugs, tobacco in any form or alcohol? Yes No \_\_\_\_\_
- 5. Do you have allergies to food, medication or drugs? Yes No \_\_\_\_\_

**HAVE YOU EXPERIENCED: (PLEASE CIRCLE APPROPRIATE ANSWER)**

- |   |                                     |
|---|-------------------------------------|
| 6. Yes No Chest pain (angina)?                      | 17. Yes No Dizziness?               |
| 7. Yes No Swollen ankles?                           | 18. Yes No Ringing in the ears?     |
| 8. Yes No Shortness of breath?                      | 19. Yes No Headaches?               |
| 9. Yes No Recent weight loss, fever, night sweats?  | 20. Yes No Fainting spells?         |
| 10. Yes No Persistent cough, coughing up blood?     | 21. Yes No Blurred vision?          |
| 11. Yes No Bleeding problems, bruising easily?      | 22. Yes No Seizures?                |
| 12. Yes No Sinus problems?                          | 23. Yes No Excessive thirst?        |
| 13. Yes No Difficulty swallowing?                   | 24. Yes No Frequent urination?      |
| 14. Yes No Diarrhea, constipation, blood in stools? | 25. Yes No Dry mouth?               |
| 15. Yes No Frequent vomiting or nausea?             | 26. Yes No Jaundice?                |
| 16. Yes No Difficulty urinating or blood in urine?  | 27. Yes No Joint pain or stiffness? |

**DO YOU HAVE OR HAVE YOU HAD: (PLEASE CIRCLE APPROPRIATE ANSWER)**

- |   |   |
|---|---|
| 28. Yes No Heart disease?                                     | 44. Yes No VD (Syphilis or gonorrhea)         |
| 29. Yes No Heart attack or heart defects?                     | 45. Yes No Herpes?                            |
| 30. Yes No Heart murmurs?                                     | 46. Yes No Kidney or bladder disease?         |
| 31. Yes No Rheumatic fever?                                   | 47. Yes No Thyroid or adrenal disease?        |
| 32. Yes No Stroke or hardening of arteries?                   | 48. Yes No Diabetes?                          |
| 33. Yes No High blood pressure?                               | 49. Yes No Psychiatric care?                  |
| 34. Yes No Stomach problems or ulcers?                        | 50. Yes No Radiation treatment?               |
| 35. Yes No TB, emphysema, lung disease or asthma              | 51. Yes No Chemotherapy?                      |
| 36. Yes No Hepatitis or other liver disease?                  | 52. Yes No Prosthetic heart valve?            |
| 37. Yes No Family history of diabetes, heart murmurs, tumors? | 53. Yes No Artificial joint?                  |
| 38. Yes No AIDS or ARC?                                       | 54. Yes No Hospitalization or surgery?        |
| 39. Yes No Tumors or cancer?                                  | 55. Yes No Blood transfusion?                 |
| 40. Yes No Arthritis or rheumatism?                           | 56. Yes No Pacemaker?                         |
| 41. Yes No Eye disease?                                       | 57. Yes No Contact lenses?                    |
| 42. Yes No Skin disease?                                      | 58. Yes No Latex Allergy?                     |
| 43. Yes No Anemia?  | 59. Yes No Prescribed Fen-Phen (Diet Pills) ? |

**WOMEN ONLY:**

- 60. Yes No Are you or could you be pregnant/nursing
- 61. Yes No Taking birth control pills?

**ALL PATIENTS:**

- 62. Yes No Do you have, or have you had, any other diseases or medical problems not listed on this form?

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

RECALL REVIEW \_\_\_\_\_ Date \_\_\_\_\_

RECALL REVIEW \_\_\_\_\_ Date \_\_\_\_\_  
RECALL REVIEW \_\_\_\_\_ Date \_\_\_\_\_