



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

Phone # -	Email Address -	Street Address 1 -
Street Address 2 -	Any Changes in Insurance? -	Policy Holder Name -
Subscriber ID # -	Subscriber Date of Birth -	Group Number -
Relationship to subscriber -	Any changes in dental health since your last visit? -	If yes, please explain: -

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

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

- | | | | |
|----------------------------------------------------|----------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Breathing Problem |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Pondimin/Fen-Phen | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Vision Loss/Blindness | <input type="checkbox"/> Yellow Jaundice | |

Are you taking any prescription medications?

-

If yes, please explain:

-

Are you allergic to any of the following?

Acrylics

Antibiotics

Aspirin

Codeine

Iodine

Latex

Local Anesthetics

Metals

Penicillin

Sulfa drugs

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

-

If yes, please explain:

-

For Women Only

Are you pregnant?

-

Females only: Are you taking birth control?

-

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 electronic signature (ESign)

Date of signing

-

Date :

FOR OFFICE USE ONLY

Provider's electronic signature (ESign)

Date of review

-

Date :