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?

- ☐ 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

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 :