Health History Update

To assist us in serving you, please complete the following confidential health questionnaire update form.
The information provided is important to your dental health.

Patient's Name _____

Patient Birthdate_____ Social Security # _____

Patient's Home Address _____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone_____ Email Address _____

Employer's Name _____ Employer's Phone Number _____

Spouse's Name _____ Spouse's Cell Phone Number _____

Physician's Name_____ Physician's Phone Number _____

MEDICAL HISTORY

1. Has there been any change in your health in the last year?
   ☐ Yes ☐ No
   If yes, what changes? _____
   _____
2. Are you being treated for any condition by a physician now?
   ☐ Yes ☐ No
   If yes, what is the condition? _____
3. Date of your last physical exam:_____
4. Are you taking any of the following? _____
   - ☐ Aspirin
   - ☐ Antibiotics
   - ☐ Cortisone or other Steroids
   - ☐ Osteoporosis (Bone Density) Medication
   - ☐ Sulfa Drugs
   - ☐ Anticoagulants (blood thinners)
   - ☐ Nitroglycerin
   - ☐ Insulin or other Diabetes Drug
   - ☐ Blood Pressure Medication
   - ☐ Herbal Supplements
   - ☐ Pain Medication
   - ☐ Other Medications _____
5. Are you allergic or reacted adversely to any of the following?
   - ☐ Aspirin
   - ☐ Penicillin
   - ☐ Clindamycin
   - ☐ Tetracycline
   - ☐ Latex Materials
   - ☐ Sulfa Drugs
   - ☐ Codeine or other Narcotic
   - ☐ Iodine
   - ☐ Barbiturates
   - ☐ Sleeping Pills or Sedatives
   - ☐ Other _____
6. Have you previously taken antibiotics (premedication) for dental appointments?
   ☐ Yes ☐ No
7. Have you experienced a bad reaction to dental anesthetic?
   ☐ Yes ☐ No
8. Have you had a major operation or been hospitalized in the last two years?
   ☐ Yes ☐ No
   If yes, please explain_____
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or lips in the last two years?
   ☐ Yes ☐ No
   If yes, please explain_____
10. Have you had any of the following?
    - ☐ Damaged/ Artificial Heart Valve
    - ☐ Cardiac Pacemaker
    - ☐ Heart Disease or Heart Attack
    - ☐ Mitral Valve Prolapse
    - ☐ Heart Murmur/ Heart Defect
    - ☐ Artificial Joint Replacement
    - ☐ Cancer
    - ☐ Stroke/ Transient Ischemic Attack (Mini Stroke)
    - ☐ High or Low Blood Pressure
    - ☐ Blood Transfusion
    - ☐ Bleeding Problem
    - ☐ Blood Disorder such as Anemia
    - ☐ Ulcers or Stomach Problem
    - ☐ Eating Disorder
    - ☐ Frequent or Severe Headaches
    - ☐ Snoring or Sleeping Problems
    - ☐ Convulsions or Epilepsy
    - ☐ Arthritis
    - ☐ Inflammatory Rheumatism
    - ☐ Glaucoma
    - ☐ Chemo or Radiation
    - ☐ Diabetes (Sugar Disease)
    - ☐ Kidney or Bladder Trouble
    - ☐ Hepatitis or Liver Trouble
    - ☐ Asthma
    - ☐ Hay Fever/ Sinus Problems
    - ☐ Tuberculosis
    - ☐ Lung/ Breathing Trouble
    - ☐ Thyroid Problems
    - ☐ AIDS or HIV Positive
    - ☐ Venereal Disease
    - ☐ Acid Reflux
    - ☐ Injury to Face or Jaw
    - ☐ Other_____
11. Do you smoke or use tobacco products?
    ☐ Yes ☐ No
    Which? _____ How much? _____ How long? _____
12. For Women:
    - ☐ May be Pregnant; Expected Delivery Date:_____
    - ☐ Nursing
    - ☐ Taking Birth Control

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____

Please Sign _____ Date _____