HEALTH HISTORY UPDATE

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PATIENT NAME: ____________________ **DOB:** ____________

Please CHECK (and CIRCLE) if you have or had any of the following:

☐ Yes ☐ No	Has your health changed in the last year
☐ Yes ☐ No	Chest pain, shortness of breath
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Bleeding problems, bruise easily Blood Thinner Medication
☐ Yes ☐ No	Headaches, Ringing in ears
☐ Yes ☐ No	Joint pain or stiffness, Arthritis
☐ Yes ☐ No	Fainting or Seizures
☐ Yes ☐ No	Heart Disease, Murmurs, Rheumatic Fever, Prosthetic Heart Valve, Stint
☐ Yes ☐ No	Pre Medicated Before Dental Treatment
☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Hepatitis or Liver Disease
☐ Yes ☐ No	TB, Asthma, or Lung Disease
☐ Yes ☐ No	Cancer, Tumors
☐ Yes ☐ No	Radiation or Chemo Treatment
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Psychiatric care
☐ Yes ☐ No	Kidney or Bladder Disease
☐ Yes ☐ No	Herpes or other STD's
☐ Yes ☐ No	HIV Positive, AIDS
☐ Yes ☐ No	Pregnant: month due____________
☐ Yes ☐ No	Birth Control Pills
☐ Yes ☐ No	Recreational drugs (ex: marijuana)
☐ Yes ☐ No	Tobacco / How much _____________
☐ Yes ☐ No	Alcohol Use/ How much ___________
☐ Yes ☐ No	Have had any joint replacements
☐ Yes ☐ No	Thyroid problem
☐ Yes ☐ No	Alzheimer's or Dementia

Other Concerns: ______________________________

List any and all **ALLERGIES:** ______________________________

List any and all **DRUGS/MEDICATIONS** you are taking: ______________________________

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List any and all **SURGERIES** in the **PAST YEAR**: ______________________________

☐ Yes ☐ No Are you seeing a doctor for a current problem? Dr Name ____________________Reason?______________

☐ Changes to below information since last visit. ☐ No Changes

Home Address: ______________________________ (city) __________ (zip) __________

Phone Number: (cell) ______________________ (work) ______________________

E-Mail Address: ______________________________

DENTAL Insurance Carrier: ________________ Employer that provides: ________________

Phone# ________________ Group#________________ ID#________________

Subscriber Name: ______________________ SS#:______________ DOB: __________

I am aware that appointment cancellations less than 24 hours may be subject to a fee ($35)
The above information is true and correct to the best of my knowledge: ** Updated 6/12/2023

Patient Signature: ______________________________ Date: ________________