HEALTH HISTORY UPDATE

DATE:__________________

NAME ____ D.O.B.____________ AGE ____________

ADDRESS ____

HOME # ____________________ WORK # ____________________ CELL # ____________________

EMAIL ______________________________ DENTAL INSURANCE CO.____________________

(Women) Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Please list all medications you are currently taking including supplements:

MEDICATION:	PRESCRIBED FOR:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

(List additional medications on back)

ALLERGIES: ____________________________________

____

Do you have a history of the following? (Check the ones that apply)

- ☐ Heart trouble
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Epilepsy
- ☐ Smoking
- ☐ Sickle Cell
- ☐ Smokeless tobacco
- ☐ Vaping
- ☐ ADD/ADHD
- ☐ Prolonged bleeding
- ☐ Immunocompromised
- ☐ Organ Transplant
- ☐ CPAP
- ☐ Trouble sleeping
- ☐ Diabetes A1C ______
- ☐ Venereal disease
- ☐ Thyroid problem
- ☐ Cancer
- ☐ Chemo
- ☐ Radiation
- ☐ Stroke/Heart Attack
- ☐ Stent(s)
- ☐ High Cholesterol
- ☐ Ulcer
- ☐ Hepatitis
- ☐ HIV
- ☐ Respiratory disease
- ☐ Blood disease
- ☐ Shortness of breath
- ☐ Acid Reflux
- ☐ Auto-Immune Disease
- ☐ Depression
- ☐ Mental Health Disorder

  Specify:__________________

Name of current physician ______________________________ Date of last physical exam ____________________

Have you ever taken any of the following medication Zometa, Aredia, Boniva, Actonel or Fosamax? ____________________

Have you ever had joint replacement surgery? ____________ Which Joint?____________________ Date__________________

Please list any medical or dental condition that you feel we should be aware of that is not previously mentioned ____________________

____

Are you happy with your smile? _______ If not, what would you like to improve? (Circle all that apply)

COLOR SIZE SPACING ALIGNMENT SHAPE

Emergency contact: Name____

Phone #____ Relationship______________________________

I certify that the Medical History is true and accurate to the best of my knowledge.

____ ______________________________

Signature Date