

PATIENT INFORMATION AND HEALTH HISTORY UPDATE FORM

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Marital status: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to contact in case of Emergency \_\_\_\_\_ ( ) \_\_\_\_\_

New Employer Name \_\_\_\_\_ WORK NUMBER ( ) \_\_\_\_\_ EXT \_\_\_\_\_

New Employer Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

If student, Name of School \_\_\_\_\_ Grade \_\_\_\_ Year in College \_\_\_\_\_

.....  
New Dental Insurance \_\_\_\_\_ Ins phone( ) \_\_\_\_\_

Effective Date \_\_\_\_\_ PLEASE GIVE INS. CARD & INFORMATION TO OUR RECEPTIONIST

NOTES:

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MEDICAL HISTORY UPDATE: PLEASE ANSWER ALL QUESTIONS TRUTHFULLY . YOUR ANSWERS ARE CONFIDENTIAL, NECESSARY, AND IMPORTANT FOR YOUR DENTAL TREATMENT.

New Changes in Health \_\_\_\_\_ When diagnosed? \_\_\_\_\_

New Medications: \_\_\_\_\_ [ ] See Attached list

New ALLERGIES to Medications or Foods \_\_\_\_\_

New Physician Name and Phone Number \_\_\_\_\_ ( ) \_\_\_\_\_

Have you ever had or been exposed to the following?

LATEX ALLERGY? Yes / No Sensitivity to the powder in latex gloves? Yes / No Notes: \_\_\_\_\_

BAD REACTION TO LOCAL ANESTHETICS? Yes / No Explain: \_\_\_\_\_

Have you taken any diet pills containing "fen-phen", fenfluramine (Pondimin), dexfenfluramine (Redux)? Yes / No  
If YES, you need to see your MD to examine your heart. You may need antibiotic Pre-med prior to dental treatment.

HIGH CHOLESTEROL? Yes / No DIABETES? Yes / No BACTERIAL ENDOCARDITIS? Yes / No

HEPATITIS A? Yes / No Vaccinated for Hepatitis A? Yes / No Notes: \_\_\_\_\_

HEPATITIS B? Yes / No Vaccinated for Hepatitis B? Yes / No Notes: \_\_\_\_\_

HEPATITIS C? Yes / No Notes: \_\_\_\_\_

HIV : tested positive? Yes / No Notes: \_\_\_\_\_

CANCER? Yes / No Notes: \_\_\_\_\_

TUBERCULOSIS? Yes / No ASTHMA? Yes / No SARS? Yes / No

Do you SMOKE? Yes / No Smoking increases risk for cancer and periodontal disease. Let us help you quit.

Do you SNORE? Yes / No Have you been diagnosed with SLEEP APNEA? Yes / No

Do you mouthbreathe? Yes / No Do you have chronic nasal congestion ( stuffy nose)? Yes / No

Do you have sensitive teeth? Yes / No Do you have oral malodor ( bad breath) ? Yes / No

Do you have any medical condition not listed? Yes / No Please Explain: \_\_\_\_\_

Patient or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Office use: Date entered in computer \_\_\_\_\_ Staff Initials \_\_\_\_\_

Revised 9/30/2004