Health History Update

Patient Name: _____ Date of Birth: _____

Home Address: _____ Preferred Contact Phone #: _____

_____ Email: _____

Emergency Contact: _____ Phone #: _____

Employer: _____ Insurance: _____

Has your INSURANCE changed? □ Yes □ No

Do you take pre-medication (antibiotics) before dental work? □ Yes □ No *If yes: What do you take? _____

Have you ever had any of the following? Please check ALL that apply:

□ Codeine Allergy
□ Penicillin Allergy
□ Allergies _____
□ Environmental Allergies
□ ADHD – Meds: _____
□ Aids / HIV Positive
□ Alzheimer's / Dementia
□ Anemia
□ Aneurysm
□ Angina / Chest Pain
□ Arthritis
□ Artificial Joints: Date ____
□ Asthma
□ Blood Disease
□ Cancer –Type _____
Year _____
□ Chemotherapy
□ Cold Sores/Fever Blisters

□ Colitis / Gastro Issues
□ Congenital Heart Condition
□ COPD
□ Depression
□ Diabetes
□ Drug/Substance or Alcohol Abuse _____
□ Emphysema
□ Excessive Bleeding
□ Fainting / Dizzy Spells
□ Fibromyalgia
□ Frequent Headaches
□ GERD
□ Glaucoma
□ Head Injuries
□ Heart Disease / Heart Attack
□ Heart Murmur
□ Heart Surgery _____

□ Hepatitis _____
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mental Disorders
□ Mitral Valve Prolapse
□ Multiple Sclerosis
□ Nervousness / Anxiety
□ Pacemaker / Year _____
□ Parkinson's Disease
□ Psychiatric Care /counseling
□ Radiation Treatment
□ Rheumatic Fever
□ Rheumatism
□ Seizures / Epilepsy
Last Episode: _____

□ Sinus Problems
□ Snoring
□ Stomach Problems / Ulcers
□ Stroke
□ TMJ Problems Clicking/Popping Jaw Joints
□ Tuberculosis
□ Tumors / Growths
□ Thyroid Problems
□ Venereal Disease
□ Other: _____
_____
_____
_____
□ Tobacco Use:
□ Cigarettes
□ Chewing Tobacco
How Often: _____

□ Osteoporosis – Meds: _____ How Long: _____
□ Blood Thinners: _____

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* Have you ever had complications with local anesthetic? □ Yes □ No

* Have you had any complications or unpleasant experiences with any dental treatment? □ Yes □ No
If yes, please explain: _____

* Have you ever had any type of surgery: □ Yes □ No Were there any complications? □ Yes □ No

* Have you been admitted to a hospital or needed emergency care within the last two years? □ Yes □ No
If yes, please explain: _____

* Are you under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

Are you currently taking any prescription or over the counter medication? □ Yes □ No
***List all medications, prescription and over the counter** (including vitamins): _____

_____

_____

♦ **Women** – Are you pregnant: _____ If yes / what month: _____ / Due Date: _____

♦♦♦ ***To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I understand that it is my responsibility to inform the doctors at Harborside Dental Associates of any such changes prior to treatment.***

_____ _____ Date: _____

Print Patient Name Signature of patient, parent or guardian