

Health History Update

Patient Name: _____ Date of Birth: _____
Home Address: _____ Preferred Contact Phone #: _____
_____ Email: _____
Emergency Contact: _____ Phone #: _____
Dental 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:

- | | | | |
|--------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Colitis / Gastro Issues | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Problems / Ulcers |
| <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> ADHD – Meds: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Aids / HIV Positive | <input type="checkbox"/> Drug/Substance or
Alcohol Abuse _____ | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Clicking/Popping Jaw Joints |
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors / Growths |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Fainting / Dizzy Spells | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nervousness / Anxiety | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pacemaker / Year _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Artificial Joints: Date _____ | <input type="checkbox"/> GERD | <input type="checkbox"/> Parkinson's Disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care /counseling | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Cancer –Type _____ | <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tobacco Use: |
| Year _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Chewing Tobacco |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Osteoporosis – Meds: _____ | Last Episode: _____ | How Often: _____ |
| <input type="checkbox"/> Blood Thinners: _____ | <input type="checkbox"/> Blood Thinners: _____ | How Long: _____ | |

Are you currently taking any prescription or over the counter medication? Yes No

***List all medications, prescription and over the counter (including vitamins):** _____

* 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: _____

◆ **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