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MEDICAL HEALTH HISTORY - UPDATE

Patient's Name: _____ Birth Date: _____ Today's Date: _____
 Address: _____ City: _____ State _____ Zip _____
 Marital Status: _____ Home Phone: _____
 Place of Employment: _____ Business Phone: _____
 Email: _____ Cell Phone: _____
 Physician's Name: _____ Referred To Us By: _____
 Dental Insurance Co. Name: _____
 Most Convenient Day & Time For Your Dental Appointments: _____
 Purpose of This First Dental Visit: _____

Person Financially Responsible For This Account: _____
 Address: _____ Home Phone: _____
 Employment Name & Address: _____ Social Security No.: _____
 Emergency Contact _____ Phone _____

Is it okay to contact your Emergency Contact with your present medical condition? ___ Yes ___ No

Please check the best answer, and complete the blank lines where appropriate:

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- Has there been any change in your health in the last few years: ___ Yes ___ No
If YES, what: _____
 - Have you undergone medical treatment for anything in the last year? ___ Yes ___ No
 - Are you on any medications now (including birth control pills)? ___ Yes ___ No
List: _____
 - Do you have any allergies? ___ Yes ___ No
 - Do you use dental floss daily? ___ Yes ___ No
 - Have you neglected replacing missing teeth? ___ Yes ___ No
 - Check if you have ever had: ___rheumatic fever or rheumatic heart disease; ___recent by-pass surgery; ___prosthetic valve replacements; ___mitral valve prolapse; ___pacemaker; ___prosthetic joint replacements; ___rheumatoid arthritis; ___lupus erythematosus; ___chemotherapy; ___high or low blood pressure; ___nervous disorders; ___hepatitis; ___venereal disease; ___ulcers; ___epilepsy; ___sinusitis; ___cancer; ___anemia; ___bleeding disorders; ___thyroid or kidney disease; ___tuberculosis; ___immune system diseases; ___other communicable diseases. ___ Yes ___ No
If YES, Please list these or others: _____
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• Is there any reason to believe that you are in a high risk group for AIDS or other immune system illness: ____ Yes ____ No
If YES, Please explain: _____

Do you still have your tonsils? ____ Yes ____ No

Do you wake up often when you are sleeping? ____ Yes ____ No

Do you wake up from a night's sleep feeling refreshed or do you feel tired and groggy? ____ Yes ____ No

Are you interested in dental implants(tooth replacement) or other treatments to replace missing teeth?
____ Yes ____ No

Have you had a joint replacement - ____ knee ____ hip ____ shoulder and/or ____ toe? ____ Yes ____ No

Please list your major dental concerns at this time: _____
