

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: _____
 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.: _____

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

- 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: _____

- 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: _____

Please list your major dental concerns at this time: _____