HEALTH HISTORY UPDATE

PATIENT NAME:_____

PHYSICIAN NAME:_____ **Telephone Number**_____
Primary Care Dr.

DATE OF LAST PHYSICAL EXAM: _____

EMERGENCY CONTACT NAME: _____
PHONE NUMBER: _____ **RELATIONSHIP** _____

MEDICAL HISTORY:

***Please be advised*:** **Your oral health can be directly affected by systemic illnesses, related treatment and medications**

PLEASE LIST ALL SURGERIES, DATES OF SURGERIES AND MEDICAL TREATMENT:

_____

_____

HAVE YOU HAD THE FOLLOWING HEALTH ISSUES:

Cardiac Valve Replacement Yes _____ No_____
Congenital Heart Defect Yes _____ No_____
Previous Endocarditis Yes _____ No_____
Artificial Joint Replacement Yes_____ No_____ **If yes, Date of Replacement** _____
Infectious Diseases Yes _____ No _____
(Hep C, Hep B, COVID-19 or other)
Immune Deficiency Disorders Yes _____ No_____
(Cancer Treatment, Transplant Patients, AIDS, HIV, ARC)
Diabetes Yes _____ No_____ **If yes, Type I** _____ **Type II**_____
Rheumatoid Arthritis Yes _____ No_____
Renal Insufficiency/Failure Yes _____ No_____
Are you currently being treated for any other health concerns? Yes _____ **No** _____
If yes, describe: _____

DO YOU HAVE ANY OF THE FOLLOWING CHRONIC HABITS THAT MAY AFFECT YOUR DENTAL HEALTH?

Oral habits, i.e., finger nail biting, cheek biting etc. _____
Use of breath mints, throat lozenges etc. _____
Grinding, clenching or bruxing of teeth _____
Cigarettes, pipe or cigar smoking _____ **If yes, how many per day**_____
Alcohol Use: Quantity _____ **Frequency** _____

CURRENT MEDICATIONS: (Please include dietary supplements and herbal medicines)

ALLERGIES: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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