H E A L T H   H I S T O R Y   U P D A T E

Name ____Date______________________________________

Please advise our staff if there have been *changes to your address, phone numbers and/or dental insurance.*

Are you under a physician's care now? Why?____Yes No

Physician's name:__________________________Phone Number:_________________Kaiser Med #_____________

Have you ever been hospitalized or had a major operation? Discuss________________________________Yes No

Have you ever had a serious injury to your head or neck? Discuss_________________________________ Yes No

Are you allergic to any medications or substances? If yes, please list and/or check box(s) below. Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other(s)_____________________

____

Are you taking any medications, supplements, pills or drugs? Please list medications:___________________Yes No

____

____

Are you on a special diet? Discuss____Yes No

Women Only (please check) Are you pregnant? ☐ Yes Due Date _________

Are you Nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Do you now have or have you ever had any of the following?

If yes to any of the starred conditions, please call prior to your appointment…premedication may be required.

☐ Heat Failure
☐ Heart Disease or Attack
☐ Angina Pectoris
☐ High Blood Pressure
☐ Heart Murmur*
☐ Rheumatic fever*
☐ Congenital Heart Lesions*
☐ Scarlet Fever
☐ Artificial Heart Valve*
☐ Heart Pacemaker*
☐ Heart Surgery
☐ Mitral Valve Prolapse*
☐ Artificial Joint*
☐ Anemia
☐ Stroke
☐ Cancer ______________________

☐ Emphysema
☐ Tuberculosis (TB)
☐ Asthma or Hay Fever
☐ Sinus Trouble
☐ Allergies or Hives
☐ Diabetes
☐ Thyroid Disease
☐ Radiation Therapy
☐ Glaucoma
☐ Pain in Jaw Joints
☐ Bruise Easily
☐ Kidney Trouble
☐ Ulcers
☐ Benign Tumor
☐ Cortisone Therapy
☐ Arthritis or Rheumatism

☐ Hepatitis Type A B C
☐ High Risk
☐ Liver Disease
☐ Yellow Jaundice
☐ Drug Addiction
☐ Hemophilia
☐ Venereal Disease
☐ Epilepsy or Seizures
☐ Nervousness
☐ Psychiatric Treatment
☐ Sickle Cell Disease
☐ Leukemia
☐ HIV
☐ A.I.D.S. or A.R.C.
☐ Other

Have you ever had any other serious illness not checked above? Discuss_____________________________ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. I understand that even though I may have some form of insurance coverage, I am fully responsible for payment of services as well as interest charges, legal fees, collection fees or any other expenses occurred to collect on my account. I also authorize the provider to release any information required to process insurance claims.

X____ Date______________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Dentist reviewed Health History ____Date_______________

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