Goodall
FAMILY DENTISTRY

Health History Update

DDS Reviewed: _____

Name: _____ Date of Birth: _____ Date: _____

Address Changes: _____ City: _____ Zip: _____

Email: _____ Mobile Phone #:_____

Insurance Changes: YES NO (Complete if necessary)

Insurance: _____ Member ID: _____ Group #:_____

Answers to the following questions are for our records only and will be considered confidential.

Please indicate if you have or had any of the following conditions. List details and any medications in space below:

Allergies:

Aspirin	Yes	No
Codeine	Yes	No
Latex	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Local Anesthetic	Yes	No
Other: _____		

Medications or additional information:

Heart:	Heart Attack	Yes	No	_____
	Heart Stent Placed	Yes	No	_____
	Mitral Valve Prolapsed	Yes	No	_____
	Heart Disease	Yes	No	_____
	Heart Failure	Yes	No	_____
	Angina Pectoris	Yes	No	_____
	Heart Surgery	Yes	No	_____
	Heart Murmur	Yes	No	_____
	Pace Maker	Yes	No	_____
	Congenital Heart Problems	Yes	No	_____
	Congestive Heart Failure	Yes	No	_____
	Rheumatic Fever	Yes	No	_____
Blood:	Hepatitis A	Yes	No	_____
	Hepatitis B	Yes	No	_____
	Hepatitis C	Yes	No	_____
	Hepatitis D	Yes	No	_____
	Hepatitis E	Yes	No	_____
	Blood Transfusions	Yes	No	_____
	HIV, AIDS, ARC	Yes	No	_____
	Liver Disease	Yes	No	_____
	Kidney Trouble	Yes	No	_____
	Thyroid Disease	Yes	No	_____
	High or Low Blood Pressure	Yes	No	_____
	Anemia	Yes	No	_____
	Diabetes	Yes	No	_____
	Epilepsy/Seizures	Yes	No	_____
	Arthritis	Yes	No	_____
	Stroke	Yes	No	_____
	Epilepsy/Seizures	Yes	No	_____
	Fainting/Dizziness	Yes	No	_____
	Artificial Joints	Yes	No	_____

(Turn Over to Complete)

Cancer: Type & Treatment	Yes	No	_____
Steroid Treatment	Yes	No	_____
Eyes: Glaucoma	Yes	No	_____
Sinus Problems or Surgery	Yes	No	_____
Psychiatric Treatment	Yes	No	_____
Eating Disorders	Yes	No	_____
Parkinson's Disease	Yes	No	_____
Alzheimer's Disease	Yes	No	_____
Dementia	Yes	No	_____
Lungs: Smoking	Yes	No	_____
Emphysema	Yes	No	_____
Persistent Cough	Yes	No	_____
Asthma	Yes	No	_____
Tuberculosis	Yes	No	_____
Recreational Drugs	Yes	No	_____
Alcoholism	Yes	No	_____
GERD	Yes	No	_____

Medications:

Bisphosphanate (Fosemax)	Yes	No
Vitamins or Herbs	Yes	No
Have you taken Redux or Pondimin (FenPhen)?	Yes	No
Do you take birth control?	Yes	No

[ ] I do not take any medications. Initials: _____

[ ] I take additional medications not listed above. (Please list here): _____

_____

_____

_____

Female: Pregnant	Yes	No

Dental:

Implants	Yes	No
Dentures or Partials	Yes	No
Cold Sores	Yes	No
Clicking or popping	Yes	No
Pain in or around your ears	Yes	No
Difficulty opening or closing	Yes	No
Difficult chewing	Yes	No
Teeth Loose	Yes	No
Bad Breath	Yes	No
History of trauma to jaw or face	Yes	No
Collect food between teeth	Yes	No
Have you been diagnosed with TMJ/TMD	Yes	No
Clenching or Grinding	Yes	No
Sensitive Teeth	Yes	No

Patient Signature: _____Date:_____