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PLEASE PRINT

PATIENT INFORMATION UPDATE

Date _____

Name _____

Home Address _____
(Street)

_____
(City) (State) (Zip Code)

Home Phone (____) _____ Business Phone (____) _____

Alternate Phone Contact _____ (____) _____
(Name) (Number)

PATIENT HEALTH UPDATE

Many medical conditions and medications can affect your periodontal health. This update is important in helping us to monitor and treat your periodontal condition and to achieve the best possible results for you.

1. Are there any changes in your medical health? Yes ☐ No ☐
   If yes, please explain. _____
2. Have you been hospitalized or had a serious illness? Yes ☐ No ☐
   If yes, please explain. _____
3. Are you pregnant? Yes ☐ No ☐
4. Do you wear a pacemaker? Yes ☐ No ☐
5. Do you have or have you ever had:

Heart trouble?	Yes ☐	No ☐	Rheumatic heart disease?	Yes ☐	No ☐	Neurosis or psychological problems?	Yes ☐	No ☐
Pain in chest?	Yes ☐	No ☐	Anemia?	Yes ☐	No ☐	Jaundice?	Yes ☐	No ☐
Shortness of breath?	Yes ☐	No ☐	Epilepsy or convulsions?	Yes ☐	No ☐	Prolonged bleeding?	Yes ☐	No ☐
Swollen ankles?	Yes ☐	No ☐	Glaucoma?	Yes ☐	No ☐	Stomach trouble?	Yes ☐	No ☐
Rheumatic fever?	Yes ☐	No ☐	Thyroid trouble?	Yes ☐	No ☐	Venereal disease, herpes or HIV/AIDS?	Yes ☐	No ☐
Heart murmur?	Yes ☐	No ☐	Goiter?	Yes ☐	No ☐	Arthritis?	Yes ☐	No ☐
Fainting or dizziness?	Yes ☐	No ☐	Low blood pressure?	Yes ☐	No ☐	Tumor?	Yes ☐	No ☐
Stroke?	Yes ☐	No ☐	Persistent cough?	Yes ☐	No ☐	Eczema or hives?	Yes ☐	No ☐
High blood pressure?	Yes ☐	No ☐	Hayfever or asthma?	Yes ☐	No ☐	Frequent headaches?	Yes ☐	No ☐
Diabetes?	Yes ☐	No ☐	Tuberculosis?	Yes ☐	No ☐	Cancer?	Yes ☐	No ☐
Bad nose bleeds?	Yes ☐	No ☐	Kidney or liver trouble?	Yes ☐	No ☐			

6. Do you have any condition, problem or disease not mentioned above? Yes ☐ No ☐
   If yes, please explain. _____
7. Please list all medications that you are presently taking. _____
8. Please list all medications that you have taken in the past year. _____
9. What drugs are you allergic to or have you reacted adversely to? _____
10. Name and city of your medical physician _____
    (Name) (City)
11. Name of your current general dentist _____
12. Have you had any recent dental work started or completed? Yes ☐ No ☐
    If yes, please explain. _____
13. Are there any changes in your dental insurance? Yes ☐ No ☐
    If yes, please explain. _____
14. Are there any special considerations that we may address for you today? Yes ☐ No ☐
    If yes, please explain. _____

Thank you for completing this form. We value you as our patient and appreciate your confidence in our practice.

Patient Signature _____ Date _____