Family and Cosmetic Dentistry
Dr. Michael Christiansen DMD
Creating Beautiful Smiles!

HEALTH HISTORY UPDATE FORM

Patient Name: (Mr. Mrs. Ms. Dr.) _____ M.I. _____

Sex: Male/Female DOB __/__/____ Nickname:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: (Please print clearly): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Soc. Sec. #: _____-_____-_____

____ Married ____ Divorced ____ Legally Separated ____ Widowed ____ Single

If Student: ____ Full time ____ Part time Employed: ____ Not ____ Full time ____ Part time

Medical Health History

Do you have or have you had any of the following?
(Please check all that apply)

- o Cancer or tumor
- o Heart ailment or angina
- o Heart murmur, mitral valve prolapse, heart defect
- o Rheumatic fever or rheumatic heart disease
- o Artificial joint or valve
- o High or low blood pressure
- o Pacemaker/Defibrillator
- o Tuberculosis or other lung problems
- o Kidney disease
- o Hepatitis or other liver disease
- o Alcoholism
- o Blood transfusion
- o Diabetes
- o Neurologic condition
- o Epilepsy, seizures, or fainting spells
- o Emotional condition
- o Arthritis
- o Herpes or cold sores
- o AIDS or HIV positive
- o Migraine headaches or frequent headaches
- o Anemia or blood disorders
- o Abnormal bleeding after extractions, surgery or trauma
- o Hay-fever or sinus trouble
- o Allergies or hives
- o Asthma

Do you smoke/use chewing tobacco? ___ Yes ___ No

Are you allergic to, or have you reacted adversely to any of the following?

- o Latex materials
- o Penicillin or other antibiotics
- o Local anesthetics (“Novocain”)
- o Codeine or other narcotics
- o Sulfa drugs
- o Barbiturates, sedatives, or sleeping pills
- o Aspirin
- o Other: _____

Are you taking any of the following?

- o Aspirin
- o Anticoagulants (blood thinners)
- o Antibiotics or sulfa drugs
- o High blood pressure medicine
- o Antidepressants or tranquilizers
- o Insulin or other diabetes drugs
- o Nitroglycerin
- o Cortisone or other steroids
- o Osteoporosis (bone density) medicine
- o Other: _____

Women:

- o May be pregnant

  Expected delivery date: _____
- o Taking hormones or contraceptives

Name or your Cardiologist: _____ Date of Last Visit: _____

Name of Pulmonologist: _____ Date of Last Visit: _____

Do you have any disease, condition, or problem not listed above? _____

_____

_____

Please list all medications you are currently taking (prescriptions, over-the-counter including herbals): _____

_____

_____

_____

_____

_____

Date of Last Sleep Study: _____ Facility of Study: _____

Ordering Doctor: _____ Are you consistently using a CPAP machine? _____

When was the last Sim Card reading? _____ Are you using an App for the CPAP? _____

DENTAL HEALTH HISTORY

- Do you experience bleeding gums when you brush or floss?
- Is your mouth dry?
- Have you ever had orthodontic (braces) treatment?
- Have you ever had a serious injury to your head or mouth?
- Have you had any problems associated with previous dental treatments?
- Are you currently experiencing dental pain or discomfort?
- Do you have sensitivity to cold, hot, sweets, or pressure?
- Have you had any periodontal (gum) treatments?
- Do you grind your teeth?
- Do you have clicking, popping or discomfort in the jaw?
- Do you have sores or ulcers in your mouth?

Date of last dental exam: _____

Date of last Dental x-rays: _____

Reason for today's office visit: _____

Please add anything else you would like us to know about _____

_____

Thank you for answering the above questions. Your answers are for our records only and will be considered confidential.

Signature of patient (or guardian) _____

Date _____