HEALTH HISTORY UPDATE

Patient Name: _____D.O.B.: _____

***** IF YOU HAVE ANY CHANGES TO YOUR ADDRESS, PHONE NUMBER, INSURANCE, OR ANY OTHER PERSONAL INFORMATION; PLEASE LET US KNOW! *****

*Please list **ANY/ALL** hospitalization(s), serious illness(es), surgeries, etc.* ***Especially placement of artificial joint(s), pins/plates, stent(s) and pacemaker(s).*** *Please list **ANY** health change the patient has had/any new diagnosis since the last visit.*

_____

_____

Are you pregnant or possibly pregnant? Yes ☐ No ☐ n/a ☐

Are you breastfeeding? Yes ☐ No ☐ n/a ☐

Have you experienced any of these sleep-related breathing disorders:

☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep ☐ None

Please list ANY/ALL allergies (including LATEX)

_____

_____

Please list ANY concerns/problems/discomfort you want to address with your hygienist/dentist:

_____

_____

*Please list **ALL** medications **(prescription/over-the-counter)** the patient is currently taking or provide a list of those medications.* ***If none; check here.*** ☐

Name of Medication	***Dosage***	***Frequency***	***Reason for Taking***

If an additional appointment is needed; please indicate the best day(s) and time(s) below:

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Morning: 8:30am-12:00pm ☐ Evening: 2:00pm-4:30pm ☐

_____	_____	_____
Patient/Guardian Signature	Date	Staff Initials
_____	_____	_____
Patient/Guardian Signature	Date	Staff Initials
_____	_____	_____
Patient/Guardian Signature	Date	Staff Initials

Covid-19 Screening

Date: ____________ **Temp:** ____________ **Signature:** ________________________________

1. Do you/they have fever, shortness of breath, cough, sinus infection, flu-like symptoms, loss of taste or smell?

   Yes________ No_________

2. Have you/they traveled out of the country in the past 14 days?

   Yes________ No_________

3. Have you/they been around anyone who has been confirmed with Covid-19 in the past 14 days?

   Yes________ No_________

Date: ____________ **Temp:** ____________ **Signature:** ________________________________

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   Yes________ No_________

2. Have you/they traveled out of the country in the past 14 days?

   Yes________ No_________

3. Have you/they been around anyone who has been confirmed with Covid-19 in the past 14 days?

   Yes________ No_________

Date: ____________ **Temp:** ____________ **Signature:** ________________________________

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Date: ____________ **Temp:** ____________ **Signature:** ________________________________

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