



# Health History Update

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Physician's name: \_\_\_\_\_

Are you under a physician's care now?  Yes  No

If yes, why? \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Have you ever been hospitalized or had an operation? If yes, describe:  
\_\_\_\_\_

Have you ever had a serious injury to your head or neck?  
If yes, describe: \_\_\_\_\_

Are you taking any medication, pills or drugs? (Including illegal/recreational drugs) \_\_\_\_\_

Are you on a special diet?  Yes  No

If yes describe \_\_\_\_\_

Are you allergic to any medications or substances?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex/Rubber

Other \_\_\_\_\_

Are you taking Bisophosphonate?  Yes  No

Women (Please check):  Pregnant/Trying to get pregnant  Nursing  Taking oral contraceptive

Do you wish to talk to the dentist private about any problem?  Yes  No

**Do you have or have you ever had any of the following:**

**If yes to any of the \* starred conditions, please call prior to your appointment. Premedications may be required.**

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medcine	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints *	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker *	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	AiDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery *	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Cold Sore)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A & C (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Use	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Snoring/Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>

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

**If yes, describe** \_\_\_\_\_

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 will inform the doctor promptly of ay medications legal or illegal, prescription or non-prescription that I am taking, in Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST:

I DO WANT A COPY OF "NOTICE"  I DO **NOT** WANT A COPY OF "NOTICE"

**Relationship to Patient:**  Self  Spouse  Parent  Other

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by Doctor:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**History review and significant findings:** \_\_\_\_\_

**Medical History Update:**

Date	Comment	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____