Health History Update

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KEELAN DENTAL

Patient Information Update

Please input the patient's information below.

If you are completing this form on behalf of the patient, please also complete the "Legal Guardian" section on page 4.

First Name *

Last Name *

MI

Patient's Preferred Name

Date of Birth *

mm/dd/yyyy

Gender *

○ Female ○ Male

Family Status *

☐ Married ☐ Single ☐ Child ☐ Other

Primary Phone Number *

(___) ___-____

Secondary Phone Number

E-Mail Address

Mailing Address *

City *

State *

Zip Code *

Emergency Contact Name *

Emergency Contact Phone Number *

Relation to Emergency Contact *

Medical History

Name of Primary Care Physician

Phone Number of Physician
(___) ___-____

Date of Last Exam
mm/dd/yyyy

Name of Specialty Provider

Phone Number of Specialist
(___) ___-____

Date of Last Exam
mm/dd/yyyy

How would you rate your overall health? * ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been hospitalized? *
○ Yes ☐ No

If yes, please explain.

Are you subject to frequent headaches? *
○ Yes ☐ No

If yes, please explain.

Are you currently or could you be pregnant? *
○ Yes ☐ No

If pregnant, what is your due date?

Do you currently smoke, vape, and/or use smokeless tobacco? *
☐ Smoke ☐ Vape ☐ Smokeless Tobacco
☐ Not Applicable

If yes, how many years have you smoked, vaped, and/or used smokeless tobacco?

How often do you smoke, vape, and/or use smokeless tobacco?

Do you currently drink alcohol? *
○ Yes ☐ No

If yes, please select appropriate response.
☐ Less than 1 drink per month
☐ 1-3 drinks per month
☐ 1-3 drinks per week
☐ 1-3 drinks per day

Comments

Allergies (Check all that apply) *

☐ Acetaminophen
☐ Aspirin
☐ Ceclor
☐ Codeine
☐ Doxycycline
☐ Erythromycin
☐ Fluoride
☐ Ibuprofen
☐ Iodine
☐ Keflex
☐ Latex
☐ Local Anesthesia with Epinephrine
☐ Metals
☐ Penicillin
☐ Sulfa
☐ Tetracycline
☐ Not Applicable

Please explain any unlisted drug allergies.

Medical Conditions (Check any that you have at present or have had in the past)

- [ ] ACE Inhibitor
- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer - Existing
- [ ] Cancer - Melanoma
- [ ] Cancer - Treated
- [ ] Cholesterol
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting/Seizures
- [ ] Glaucoma
- [ ] Gout
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High/Low Blood Pressure
- [ ] HIV
- [ ] HPV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lumps in Mouth
- [ ] Mental Disorders
- [ ] Mitral-Valve Prolapse
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Rheumatic Fever
- [ ] Sinus Issues
- [ ] STD
- [ ] STI
- [ ] Stomach Issues
- [ ] Stomach Ulcers
- [ ] Stroke
- [ ] Thyroid Issues
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Venereal Disease
- [ ] Not Applicable

*

Please explain any unlisted medical conditions.

Medications (Check all that apply)

- [ ] Birth Control
- [ ] Blood Thinners
- [ ] Dietary Supplements
- [ ] Erectile Dysfunction Medication
- [ ] Fosamax
- [ ] Osteoporosis Medication
- [ ] Premedication
- [ ] Weight Control
- [ ] Not Applicable

*

If you are taking medication, please explain.

List additional medications, supplements, and/or vitamins taken within the last two years:

Describe any current medical treatment, impending surgery, or other treatment.

Dental Information

What is your immediate concern? (Use the back of this page if more space is needed)

How fearful of the dentist are you? *

- [ ] Not Fearful
- [ ] Some Fear
- [ ] Very Fearful
- [ ] Require Sedation

Please explain any dental changes since your last visit with Keelan Dental.

Legal Guardian Information

Please input information of patient's legal guardian.

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number (__-__-____) | Relation to Patient

Phone Number | Secondary Phone Number | E-Mail Address

Mailing Address

City | State | Zip Code

Person Responsible for Payment Information

Please input information of the person who is responsible for payment if different than the patient or legal guardian.

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number | Relation to Patient

Phone Number | Secondary Phone Number | E-Mail Address

Mailing Address

City | State | Zip Code

Acknowledgement

☐ By checking this box, I acknowledge that the above information is correct. I understand that it is my responsibility to inform Keelan Dental of any changes to this information. *

Today *

mm/dd/yyyy

Signature *