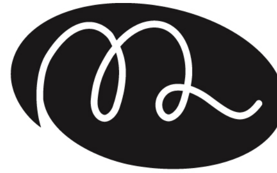

MelissaLee DDS

HEALTH HISTORY UPDATE

PATIENT NAME ____ TODAY'S DATE __________________

CURRENT ADDRESS ____

CONTACT PHONE NUMBER______________________________EMAIL____________________________

ARE YOU BEING TREATED FOR AN ILLNESS OR HAD SURGERY IN THE LAST YEAR? **O** YES **O** NO

If yes, please explain ____

DATE OF LAST PHYSICAL/WELLNESS EXAM _____________________________________

DO YOU REQUIRE PREMEDICATION (ANTIBIOTICS) PRIOR TO DENTAL TREATMENT AS INSTRUCTED BY A PHYSICIAN? **O** YES **O** NO If yes, for what condition? ______________________

PLEASE LIST ALL MEDICATIONS YOU TAKE INCLUDING OVER THE COUNTER/HERBAL REMEDIES____

____

____

PLEASE LIST ALL ALLERGIES ____

ANY REACTIONS TO ANESTHESIA? **O** YES **O** NO

ARE YOU OR IS THERE A CHANCE YOU ARE PREGNANT? **O** YES **O** NO

DO YOU USE ALCOHOL? **O** YES **O** NO TOBACCO PRODUCTS (including vaping)? **O** YES **O** NO

If yes, how much and for how long? ____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect or false information can adversely affect my health.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ____