Health History Update

Lake Highlands Dental
8610 Greenville Ave, Suite 150 ***Office: (214)343-9280***
Dallas, TX 75243

Patient Name: ________________________________ Home Phone: ___________________________
Address: ____________________________________ Cell #: _________________________________
____________________________________ Email: __________________________________

✓ **Check if you have any of the following problems since your last visit:**

□Bad Breath □Grinding Teeth □Sensitivity to Hot
□Bleeding Gums □Loose Teeth □Sensitivity to Sweets
□Clicking/Popping Jaw □Sensitivity when Biting □Sores/Growths in mouth
□Food Between □Sensitivity to Cold □Broken Fillings
How often are you flossing? ___________________________

Medical History

+Women: Are you pregnant: □Yes □No Nursing: □Yes □No Taking Birth Control Pills: □Yes □No

Medical Doctor of Record: ___________________________________ Phone#:______________________________
Date of last Physical: ______________________ _____________
Any Serious Illnesses or Surgeries: □Yes □No If Yes, describe: ____

✓ **Check if you have/had any of the following:**

□Acid Reflux □Cortisone Treatments □Hepatitis □Scarlet Fever
□Anemia □Persistent Cough □High Blood Pressure □Skin Rashes
□Arthritis □Cough up Blood □HIV/Aids □Sinus Problems
□Artificial Heart Valves □Diabetes □Jaw Pain □Stroke
□Artificial Joints □Epilepsy □Kidney Disease □Swelling Feet/Ankles
□Asthma □Fainting □Liver Disease □Thyroid Problems
□Back Problems □Glaucoma □Mitral Valve Prolapse □Tobacco Habit
□Blood Disease □Headaches □Pacemaker □Tonsillitis
□Cancer □Heart Murmur □Radiation Treatment □TB
□Chemical Dependency □Hemophilia □Respiratory Disease □Ulcers
□Chemo □Rheumatic Fever □STD
□Circulatory Problems
□Auto Immune Disorder: ____
□Other (not listed above): ____

Please list all medications you are currently taking: ____
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Allergies: □Aspirin □Penicillin □Barbiturates □Sulfa □Codeine □Latex
□Local Anesthetic □Other: ____________________________________

Pharmacy Name: ____ Phone #:_______________________

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the update of this form.

Signature: ____________________________________ Date: __________________________