Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Update: Health History Form

Date: _____

Please help us by updating your contact information:

Name: _____

Address: _____
Street Address City Zip Code

Home Phone:_____ *__Cellular Phone__:_____ __

Work Phone:_____ __*Email Address__:_____

Emergency Contact: _____

What are the most convenient method(s) to confirm your dental appointments?
☐ Home Phone ☐ Cellular Phone ☐ Office Phone ☐ E-mail

Any change in Dental Insurance Information Yes: _____ No: _____

Your Physician's Name:_____Telephone # _____ Last Visit Date:_____

Any History Of:

Allergy to Dental Anesthetic Yes: _____ No: _____

Arthritis Yes: _____ No: _____

Artificial Joints Yes: _____ No: _____

Asthma Yes: _____ No: _____

Cancer Yes: _____ No: _____

Diabetes Yes: _____ No: _____

Emotional Stress Yes: _____ No: _____

Epilepsy Yes: _____ No: _____

GI (Stomach) Problems Yes: _____ No: _____

Glaucoma Yes: _____ No: _____
Headaches Yes: _____ No: _____
Heart or Valve Problems Yes: _____ No: _____

Heart Murmur Yes: _____ No: _____

Hepatitis Yes: _____ No: _____

High Blood Pressure Yes: _____ No: _____
High Cholesterol Yes: _____ No: _____

HIV + or AIDS Yes: _____ No: _____

Kidney/ Liver/ Bladder Disease Yes: _____ No: _____

Pregnant Currently Yes: _____ No: _____

Prolonged Bleeding Yes: _____ No: _____

Rheumatic Fever Yes: _____ No: _____

Sinus Trouble/Hay Fever Yes: _____ No: _____

Sleep Apnea (Unrestful sleep) Yes: _____ No: _____

Smoking/Tobacco Use Yes: _____ No:_____

Stroke Yes: _____ No: _____

Thyroid Disease Yes: _____ No: _____

Tuberculosis Yes: _____ No: _____

Please List Any Drug Allergies:

_____

_____

Do you currently take antibiotic premedication for your visit?

Yes: _____ No: _____

Please List All Current Medication(s): Name and Dosage

1._____

2. _____

3. _____

4. _____

5. _____

Please List Current Over the Counter Medications, or Supplements

1._____

2. _____

3. _____

All the information provided is current and correct:

Signature:_____

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