Meister Dental Group and Associates

5380 Pleasant Avenue, Suite 3B Fairfield, OH 45014
10067 Harrison Avenue, Suite A Harrison Ohio 45030

HEALTH HISTORY UPDATE

PATIENT INFORMATION: ***(please print)***

Name: ______________________________ Date of Birth: _______________
Address: ______________________________City: _______________State: _____ Zip: _________
Home Phone: (___)______________Cell Phone: (___)_____________ Work Phone: (___)_______________
Preferred method of contact: Home □ Cell □ Work □ No Preference □
Email: _______________________________ Patient Employer/School: ____________________________
Emergency Contact: ___________________ Relationship: ______________Phone: (___)_______________

Insurance Information:

HAS YOUR INSURANCE CHANGED WITHIN THE LAST 6 MONTHS? ☐ Yes ☐ No

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MEDICAL HISTORY **Are you: Pregnant □ / Nursing □** # Weeks pregnant:______

Current medications (*please list all below):*
____
____

Allergies:
____
____

Check if you have had any of the following:

□ Abnormal bleeding
□ AIDS/HIV
□ Anemia
□ Arthritis/Rheumatism
□ Artificial Heart Valves
□ Artificial Joints
Date of surgery: _______
□ Asthma
□ Back Problems
□ Blood Disease/Disorder
Explain:_________
□ Cancer
Type: ___________
Date diagnosed: ________
□ Chemotherapy
□ Congenital Heart Defect
□ Cortisone Treatments
□ Cough
□ Diabetes Type: ____
Controlled? Y/N

□ Epilepsy
□ Fainting/Dizziness
□ Fibromyalgia
□ Glaucoma
□ Headaches/Migraines
□ Heart Problems
Explain: _______________
□ Hemophilia
□ Hepatitis Type: __
□ Heart Murmur
□ Heart Problems
□ High Blood Pressure
□ Low Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Mitral Valve Prolapse
□ Nervous Problems
□ Pacemaker

□ Psychiatric Care
□ Radiation Therapy
Date: ________
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Skin Rash
□ Stroke
□ Thyroid: Hyperthyroidism
□ Thyroid: Hypothyroidism
□ Tonsillitis
□ Ulcer
□ Venereal Disease
Type: _____________
Recent surgeries:
____
Other conditions not specified:
____
____

Do you currently drink alcohol? YES or NO If so, # drinks/week _____
Do you currently smoke or use smokeless tobacco? YES or NO If so, for how long? _____ # Packs/Day: ______

X______________________________ ___________________ ________
Signature of Patient Date Dr. Initial