



LIBERTY DENTAL ASSOCIATES

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Building #5

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CONFIDENTIAL HEALTH HISTORY UPDATE

ALL INFORMATION LISTED IS CONFIDENTIAL AND IS FOR MEDICAL PURPOSES ONLY

DATE: ___ / ___ / ___ NAME: _____

MY E-MAIL ADDRESS: _____

CIRCLE

1. Since your last dental appointment, have you been seen by a Medical Doctor? YES NO

If yes, please list who, when, and for what:

2. Please list all medications (prescription or over-the-counter), drugs, or pills you are currently taking. If you have a list, please give this to the Office Coordinator so they can copy this. Include herbal medicines.

3. Please list any allergies (including medicines) you have:

4. Are you having a dental problem today? YES NO

If yes, please describe: _____

5. Have you had any areas of soreness, discomfort, or pain in the mouth, or with your teeth? YES NO

If yes, please describe: _____

6. Do you have any type of heart stents, joint replacements, Mitral-valve Prolapse, or a condition which might require pre-operative antibiotics? YES NO

If yes, please explain:

7. Do you have any other medical condition not listed? YES NO

If yes, please list:

8. Do you like the way your teeth look and appear? YES NO

If no, what would you change if you could: _____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient, Parent, or Guardian

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PRE-MEDICATION REQUIRED? YES NO PER DR.