



scott dooley dentistry

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**Health History Update**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_ Address: \_\_\_\_\_

Current Medications-including, Aspirin, Vitamins  
& Herbals:

Health Changes: \_\_\_\_\_

1. \_\_\_\_\_

Purpose: \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

Purpose: \_\_\_\_\_

Recent Hospitalizations; State Reason: \_\_\_\_\_

3. \_\_\_\_\_

Purpose: \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

Pre-Med was Taken: Yes \_\_\_\_ No \_\_\_\_

Purpose: \_\_\_\_\_

Not Required \_\_\_\_

Physician's Name: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_