MY FAMILY DENTAL

Medical History Update

Date: _____ Last Name: _____ First Name: _____

Birthdate: _____ Patient's BP: _____ Patient's Temp: _____

Physician's Name: _____ Physician's Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Y	N		Y	N	
☐	☐	Are you under the care of a physician?	☐	☐	Do you use tobacco?
☐	☐	Any hospitalizations or major operations?	☐	☐	Do you use recreational drugs?
☐	☐	Are you taking medications / pills?			WOMEN ONLY:
☐	☐	Have you taken bisphosphonates for osteoporosis?	☐	☐	Are you pregnant or trying to get pregnant?
☐	☐	Have you taken Phen-Fen or Redux?	☐	☐	Do you take oral contraceptives?
☐	☐	Are you taking a blood thinner?	☐	☐	Are you nursing?

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Metal	Y	N	Codeine	Y	N	Latex	Y	N	Local Anesthetics
Y	N	Acrylic	Y	N	Sulfa Drugs	Y	N	Penicillin	Y	N	Other			

If yes, please explain: _____

Do you have, or have you had, any of the following? Check each box seperately.

Y	N		Y	N	
☐	☐	Allergies, Hives, or Rash	☐	☐	Heart Attack/Failure
☐	☐	Sickle Cell Disease	☐	☐	Parathyroid Disease
☐	☐	Artificial Heart Valve	☐	☐	Tumors or Growths
☐	☐	Excessive Bleeding	☐	☐	Cold Sores/Fever Blisters
☐	☐	Hypoglycemia	☐	☐	Heart Murmur
☐	☐	Sinus Trouble	☐	☐	Psychiatric Care
☐	☐	Artificial Joint(s)	☐	☐	Ulcers
☐	☐	Excessive Thirst	☐	☐	Venereal Disease
☐	☐	Irregular Heartbeat	☐	☐	Congenital Heart Disorder
☐	☐	Spina Bifida	☐	☐	Heart Pacemaker
☐	☐	Asthma	☐	☐	Heart Problems or Surgery
☐	☐	Fainting Spells/Dizziness	☐	☐	Convulsions
☐	☐	Kidney Problems	☐	☐	Radiation Treatments
☐	☐	Stomach/Intestinal Disease	☐	☐	Recent Weight Loss
☐	☐	Blood Disease	☐	☐	Yellow Jaundice
☐	☐	Frequent or Chronic Cough	☐	☐	Arteriosclerosis
☐	☐	Shingles	☐	☐	Tonsillitis
☐	☐	Emphysema	☐	☐	Chemotherapy
☐	☐	High Blood Pressure	☐	☐	Hay Fever
☐	☐	Angina Pectoris	☐	☐	Pain in Jaw Joint(s)
☐	☐	Arthritis / Gout	☐	☐	Tuberculosis
☐	☐	Epilepsy or Seizures	☐	☐	Chest Pains
☐	☐	Easily Winded	☐	☐	Cancer
☐	☐	Herpes	☐	☐	Glaucoma
☐	☐	Scarlet Fever	☐	☐	Mitral Valve Prolapse

Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Leukemia
☐	☐	Cortisone Medication	☐	☐	Blood Transfusion
☐	☐	Hemophilia	☐	☐	Frequent Diarrhea
☐	☐	Renal Dialysis	☐	☐	Liver Disease
☐	☐	Alzheimers's Disease	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Lung Disease
☐	☐	Hepatitis A	☐	☐	Frequent Headaches
☐	☐	Rheumatic Fever	☐	☐	Low Blood Pressure
☐	☐	Anaphylaxis	☐	☐	Swelling of Limbs
☐	☐	Drug Addiction	☐	☐	Bruise Easily
☐	☐	Hepatitis B & C	☐	☐	Genital Herpes
☐	☐	Rheumatism	☐	☐	Thyroid Disease/Problems
☐	☐	Anemia			

Have you ever had any serious illness not listed above? Y N If yes, please explain:

_____

List all medications that you are now taking:

Birth Control _____ _____

_____ _____

_____ _____

Y	N		Y	N	
☐	☐	Are you on a special diet?	☐	☐	Immunosuppressed?
☐	☐	Have you had orthopedic surgery?	☐	☐	Gained or lost more than 10lbs in past year?
☐	☐	Are you experiencing discomfort at this time?	☐	☐	Have you had cosmetic surgery?
☐	☐	History of head/neck radiation treatment?	☐	☐	Have you had a head or neck injury?
☐	☐	Do you ever wake up short of breath?	☐	☐	Do you use two pillows to sleep?
☐	☐	Admitted to a hospital in last 2 years? What for?			

I understand that the above information is necessary to provide dental care in a safe and efficient manner. I have accurately answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to me (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

I, hereby, authorize the dentist and team to take x-rays, study models, photographs, or use any other diagnostic aid as deemed appropriate by the dentist to make a thorough diagnosis of my or the Patients' dental needs. I also authorize the dentist to perform and use any and all forms of treatment, medication, and therapy that may be indicated in connection with my dental care.

Name of Parent/Guardian If Applicable: Name of Dentist:

_____ _____

Patient Signature: Dentist Signature:

_____ _____