

YOUR 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

Are you under the care of a physician?

Any hospitalizations or major operations?

Are you taking medications / pills?

Have you taken bisphosphonates for osteoporosis?

Have you taken Phen-Fen or Redux?

Are you taking a blood thinner?

Y N

Do you use tobacco?

Do you use recreational drugs?

WOMEN ONLY:

Are you pregnant or trying to get pregnant?

Do you take oral contraceptives?

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 separately.

Y N

Allergies, Hives, or Rash

Sickle Cell Disease

Artificial Heart Valve

Excessive Bleeding

Hypoglycemia

Sinus Trouble

Artificial Joint(s)

Excessive Thirst

Irregular Heartbeat

Spina Bifida

Asthma

Fainting Spells/Dizziness

Kidney Problems

Stomach/Intestinal Disease

Blood Disease

Frequent or Chronic Cough

Shingles

Emphysema

High Blood Pressure

Angina Pectoris

Arthritis / Gout

Epilepsy or Seizures

Easily Winded

Herpes

Scarlet Fever

Y N

Heart Attack/Failure

Parathyroid Disease

Tumors or Growths

Cold Sores/Fever Blisters

Heart Murmur

Psychiatric Care

Ulcers

Venereal Disease

Congenital Heart Disorder

Heart Pacemaker

Heart Problems or Surgery

Convulsions

Radiation Treatments

Recent Weight Loss

Yellow Jaundice

Arteriosclerosis

Tonsillitis

Chemotherapy

Hay Fever

Pain in Jaw Joint(s)

Tuberculosis

Chest Pains

Cancer

Glaucoma

Mitral Valve Prolapse

Y N

- AIDS/HIV Positive
- Cortisone Medication
- Hemophilia
- Renal Dialysis
- Alzheimer's Disease
- Diabetes
- Hepatitis A
- Rheumatic Fever
- Anaphylaxis
- Drug Addiction
- Hepatitis B & C
- Rheumatism
- Anemia

Y N

- Leukemia
- Blood Transfusion
- Frequent Diarrhea
- Liver Disease
- Stroke
- Lung Disease
- Frequent Headaches
- Low Blood Pressure
- Swelling of Limbs
- Bruise Easily
- Genital Herpes
- Thyroid Disease/Problems

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

List all medications that you are now taking:

Y N

- Are you on a special diet?
- Have you had orthopedic surgery?
- Are you experiencing discomfort at this time?
- History of head/neck radiation treatment?
- Do you ever wake up short of breath?
- Admitted to a hospital in last 2 years? What for?

Y N

- Immunosuppressed?
- Gained or lost more than 10lbs in past year?
- Have you had cosmetic surgery?
- Have you had a head or neck injury?
- Do you use two pillows to sleep?

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: