

# 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: \_\_\_\_\_

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

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

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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: