380 Family Dentistry

Going the extra mile for your family's smile

Annual Medical History Update

Patient Name:_____

For your safety and according to state law, we must update this information annually.

Address	Mobile Number	Home Number
Email	Emergency Contact Name and Number	

Have you had any surgeries or hospital visits in the last 12 months? **Y** **N**

Have you had any changes in your **Medical/dental** history in the last 12 months? **Y** **N**

Joint replacements, heart, autoimmune condition, accident/trauma or fall, etc. **Y** **N**

If yes to any of the above, please explain: _____

_____

What specific questions or concerns you would like us to address today? (circle any):

Headaches/Migraine relief Veneers Whiten teeth Straighten teeth Sensitivity Pain

Replace missing teeth Implants Snoring Other _____

Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you Now or in the Past:

Y N Heart attack / Chest Pain	Y N Implant or Artificial Joint	Y N Autoimmune Disease	Y N Kidney or Liver Problems
Y N Heart Disease	When? _____	Y N Difficult Staying Awake	Y N Epilepsy or Seizures
Y N Pacemaker	Y N Anemia or Blood Disorder	Y N Fatigue	Y N Asthma/Inhaler use
Y N Heart Value Disorder	Y N Excessive Bleeding	Y N Headaches or Migraines	Y N Tuberculosis, Lung Problems
Y N Stroke	Y N Depression	Y N Head/Neck/Jaw Pain	Y N Hepatitis A B C D
Y N High Blood Pressure	Y N Anxiety	Y N Fainting or Blackouts	Y N AIDS or HIV Infection
Y N Diabetes 1 2 Gestational	Y N Reflux, Ulcers, Heartburn	Y N Tobacco/Vaping use	Y N Thyroid Disease
Y N Mouth Breather	Y N Difficult Swallow/Chewing	Y N Drug/Alcohol Dependency	Y N Sleep Apnea/Snoring
Y N Cancer/Radiation/Chemo	Y N Dry Mouth	Y N Head Injury/Fall	Y N Endometriosis / Fibroids

Y N **Has your physician advised you to take antibiotics before dental treatment?** Reason _____

Please circle if allergic to: penicillin antibiotics sedatives latex codeine metals mint other_____

(Women) Are you currently pregnant? _____ If yes, how many weeks? _____

I authorize my information to be released to: Name _____ Relation_____

Please list any drugs, medications, over-the-counter meds, or vitamins you are currently taking:

Responsible Party Signature: _____ Date: _____

Doctor/Hygienist Signature: _____ Date: _____