DeSoto Family Dentistry

Medical History Update

Patient First Name: _____ Last Name: _____
Home Phone #: _____ Cell Phone #: _____
Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Last Physical Exam: _____ Physician: _____ Office#: _____
Height: _____ Weight: _____
Are you under medical treatment now? Yes/No If yes, list reasons_____
_____
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes/No
If yes, please explain:_____
Do you require any pre-medications prior to dental treatment? Yes/No If yes, please list:_____
Are you taking any medications? (Including non-prescription) Yes/No
If yes, please list **ALL:** _____

Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No
Have you ever taken Fen-Phen/Redux? ☐Yes ☐No
Are you wearing contact lenses? ☐Yes ☐No
Do you have a persistent cough? ☐Yes ☐No

WOMEN ONLY:
Are you pregnant or think you may be pregnant?
☐ Yes ☐No
Are you nursing? ☐Yes ☐No
Are you taking oral contraceptives? ☐Yes ☐No

Are you allergic to have you had any reactions to the following: (Please circle all that apply)

Local anesthetics (e.g. Novocain)
Penicillin
Sulfa Drugs
Barbiturates
Sedatives
Iodine
Aspirin
Any Metals
Latex
Other:_____
_____
_____

Do you have or have you had any of the following? (Circle all that apply)

AIDS/HIV Infection
Anemia
Angina
Arthritis, Rheumatism
Asthma
Cancer
Cardiac Pacemaker
Chest Pains
Diabetes
Depression/Anxiety
Easily Winded
Emphysema
Epilepsy/Seizures
Fainting/Dizziness
Family History Diabetes
Frequently Tired
Glaucoma
Hay Fever/Allergies
Heart Attack
Heart Disease
Heart Murmur
Heart Trouble
Hepatitis/Jaundice
High Blood Pressure
Joint Replacement/Implant
Kidney Disease
Leukemia
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Radiation Therapy
Recent Weight Loss
Respiratory Problems
Rheumatic Fever
Sexually Transmitted Disease
Stomach Ulcers
Stroke
Swollen Ankles
Thyroid Problem
Tuberculosis
Other: _____
_____

Patient Dental History

Name of previous Dentist and Location: _____ Last Exam:_____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____ _____
Patient or Parent/Legal Guardian Signature Print Name Date