— HALL FAMILY —
DENTAL
MATT HALL, DDS

**Confidential Health History Update** Today's date: _____

Name: _____

Cell phone: _____

Email: _____

Mailing address: _____

Has your dental insurance changed in the last year? _____

**Medical Questions**: Please circle appropriate answer (leave blank if you do not understand)

1. Yes / No Is your general health good?
   If no, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If yes, explain: _____
3. Yes / No Have you been to the hospital or been to the ER or had a serious illness in the last three years? If yes, explain: _____
4. Yes / No Are you being treated by a physician now?
   If yes, explain: _____
5. Yes / No Are you in pain now?
   If yes, explain: _____

**Have you ever experienced any of the following?** Please circle if yes.

| | | | |
|---|---|---|---|
| Chest pain (angina) | Blood in stool | Frequent vomiting | Fainting spells |
| Diarrhea recurring | Frequent urination | Dry Mouth | Bruise Easily |
| Jaundice | Night sweats | Difficulty urinating | Excessive thirst |
| Constipation recurring | Ringing in ears | Difficulty swallowing | Persistent cough |
| Swollen ankles | Bleeding problems | Blurred vision | Sinus problems |
| Shortness of breath | Blood in urine | Fevers, recurring or severe | |
| Headaches, recurring, severe, or one-sided | | Recent significant weight loss | |

Other: _____

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**Are you allergic to or have you had a reaction to any of the following?** Please circle if yes.

| | | | |
|---|---|---|---|
| Valium or other sedatives | Aspirin | Latex | Nitrous oxide |
| Penicillin or other antibiotics | Food | Local anesthetic | Metal |

Other: _____

**Have you ever had or do you currently have any of the following?** Please circle if yes.

| | | | |
|---|---|---|---|
| Heart Disease | AIDS/HIV | Psychiatric care | Surgeries |
| Family history heart disease | Heart attack | Osteoporosis | Hospitalization |
| Thyroid disease | Artificial joint | Diabetes | Asthma |
| Heart defects | Tumors or cancer | Chemotherapy | Heart murmurs |
| Sexually transmitted disease | Herpes | Radiation | Rheumatic fever |
| Canker or cold sores | Skin disease | Arthritis, rheumatism | Anemia |
| Hardening of arteries | Liver disease | High blood pressure | Eye disease |
| Emphysema or lung disease | Seizures | Stroke | Transplants |
| Kidney or bladder disease | Cosmetic surgery | Eating disorders | Tuberculosis |
| Sleep apnea | Neurological disorder | | |

Please explain circled conditions: _____

_____

_____

**Are you taking or have you taken any of the following in the last three months?** Circle if yes.

| | | |
|---|---|---|
| Recreational drugs | Antibiotics | Alcohol |
| Tobacco in any form | Weight loss medication | Herbal supplements |
| Anti-depressants | Supplements | Biphosphonate (Fosamax) |
| Over-the-counter medicines | | |

Please list all prescriptions and medications you are currently taking:

_____

_____

_____

**Women only.** Please circle appropriate answer.

1. Yes / No Are you or could you be pregnant? If yes, what month?_____
2. Yes / No Are you breastfeeding?
3. Yes / No Are you taking birth control medication?

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**All Patients:** Please circle appropriate answer.

1. Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form? If yes, explain: _____
2. Yes / No Have you ever been pre-medicated for dental treatment?
   If yes, explain: _____
3. Yes / No Have you ever taken Fen-Phen? If yes, when? _____
4. Yes / No Is there any issue or condition you would like to discuss with the dentist in private?

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

I authorize the dentist to contact my physician.

Patient's signature: _____ Date: _____

Physician's name: _____ Phone: _____

**Whom would you like us to contact in case of emergency?**

**Name:** _____ **Phone:** _____

**Relationship:** _____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

_____ Date: _____

Signature of patient (parent of guardian)

_____ Date: _____

Signature of Dentist