

MEDICAL HISTORY UPDATE



GRAND DENTAL ASSOCIATES
FARNSWORTH DENTAL GROUP
CHANNAHON FAMILY DENTISTRY

Name: _____ Date: _____

Please list any changes in address, phone numbers and insurance information:

Home # _____ Work # _____ Cell # _____

Physician's Name: _____ Phone # _____

Date of Last Doctor's Visit: _____

Your Current Physical Health is: Good Fair Poor

If you are currently under the care of a physician, please explain:

Do you smoke or use tobacco in any other form? Yes No

Please list all prescription medications, vitamins and herbal supplements that you are currently taking:

Are you currently taking, or have you ever taken any bisphosphonate drugs (Fosamax/Alendronate, Boniva/Ibandronate, Actonel/Risedronate, Aredia/Pamidronate, Zometa/Zoledronate, etc.)? **Yes** **No**
If yes, drug name: _____ **Date(s) taken:** _____

Do you need to take an antibiotic (pre-medicate) before dental treatment? Yes No

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Codeine	Y	N	Dental Anesthetics
Y	N	Erythromycin	Y	N	Tetracycline	Y	N	Aspirin / Ibuprofen

Please list any other allergies: _____

For Women:
Are you pregnant? Y N Week # _____ Are you on birth control? Y N

Have you ever been treated for, or had, any of the following medical problems or conditions:

Y	N	Heart Attack / Disease, Stroke	Y	N	Hemophilia/Abnormal bleeding
Y	N	Heart Murmur	Y	N	Rheumatic Fever
Y	N	Heart Surgery / Pacemaker	Y	N	Angina
Y	N	Anemia	Y	N	High / Low Blood Pressure
Y	N	Cortisone medication	Y	N	Asthma
Y	N	Hepatitis Type A / B / C	Y	N	Thyroid / Adrenal Disease
Y	N	Cancer / Chemotherapy	Y	N	HIV / AIDS
Y	N	Diabetes	Y	N	Kidney Problems
Y	N	Sinus Problems	Y	N	Fever Blisters
Y	N	Arthritis	Y	N	Tuberculosis (TB)
Y	N	Drug / Alcohol Abuse	Y	N	Psychiatric Problems
Y	N	Epilepsy/Seizures/Fainting	Y	N	Joint Prosthesis
Y	N	Mitral Valve Prolapse			

If you have any other medical conditions not listed above, please explain:

Patient (Parent or Guardian) Signature _____

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