— 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 experienced any of the following in the last 3 years? YES or NO (circle)

*** If yes, please circle which ones ***

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 or have had a reaction to the following? YES or NO (circle which ones 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? YES or NO (circle)
*** If yes, please circle which ones ***

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 3 months? YES or NO (circle)
*** If yes, please circle which ones ***

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