St. Johns Family Dentistry

# Medical History Update

**Date** ____________

**Name** ______________________ ○ Married ○ Single ○ Minor ○ Male ○ Female
LAST FIRST M

**Address** ______________________
STREET APT # CITY STATE ZIP

**Birthdate** ____________ **Telephone** Home ____________ Office ____________
MO DAY YR

**E-mail address** ______________________ **Cell phone** ____________

**Place of Employment (or School)** ____________ **Grade** ______ **S.S. #** ____________

**Dental insurance co.** ______________________ **Group no.** ____________

## Family Information

| | **Husband, Father or Guardian** | **Wife, Mother or Guardian** |
|---|---|---|
| Name | LAST FIRST M | LAST FIRST M |
| Address | STREET CITY STATE ZIP | STREET CITY STATE ZIP |
| Telephone # | HOME # WORK # | HOME # WORK # |
| Birthday/S.S. # | MO DAY YR SS# | MO DAY YR SS# |
| Employer | EMPLOYER | EMPLOYER |
| Dental insurance co. | DENTAL INSURANCE | DENTAL INSURANCE |
| Group # | GROUP # | GROUP # |

**Please list other patients of St. Johns Family Dentistry that should be included on your account:**

______________________

______________________

**Circle if you now have or have had any of the following:**

| | | | | |
|---|---|---|---|---|
| Heart trouble | Heart surgery | Stroke | Asthma | Hepatitis |
| High/low blood pressure | Blood disease | Diabetes | Sinus trouble | Jaundice |
| Heart murmur | Anemia | Excessive thirst | Emphysema | Recent weight loss |
| Rheumatic fever | Chest pain | Artificial joints/hips | Frequent cough | Cancer |
| Congenital heart lesion | Shortness of breath | Kidney trouble | Lung disease | Thyroid disease |
| Artificial heart valve | Swelling of feet/hands | Ulcers | Tuberculosis | Radiation therapy |
| Heart pacemaker | Fainting or dizziness | Scarlet fever | Liver disease | Arthritis/gout |
| Pain in jaw joints | Glaucoma | Epilepsy or seizures | Nervousness | Alzheimer's disease |
| Hypoglycemia | Psychiatric care | Drug addiction | Hemophilia | AIDS |
| Venereal disease | Cold sores | Bruise easily | Sickle cell | Organ transplant |
| Swollen glands | Contact lenses | Metal allergy | Latex allergy | Frequent headaches |

Have you ever had any other serious illness not circled above? ______________________ yes no

If yes, please describe ______________________

Do you wish to talk to the doctor privately about any problem? ______________________ yes no

Patient Signature (parent or guardian) ____________ Doctor's Signature ____________

## Medical Updates

| **Date** | **Exceptions** | | **Patient's Signature** | **Reviewed By** |
|---|---|---|---|---|
| ______ | ____________ | None | ____________ | Dr. ____________ |
| ______ | ____________ | None | ____________ | Dr. ____________ |
| ______ | ____________ | None | ____________ | Dr. ____________ |
| ______ | ____________ | None | ____________ | Dr. ____________ |