Grandville
Family Dental Care, P.C.

Patient Annual Medical History Update

Todays Date _____

Name _____ Phone #: _____

Birthdate _____ Cell Phone #: _____

Do you have a Personal Physician? Y or N

Physician's Name _____

Physician's Phone # _____

Date of last visit _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a Physician Y or N

Please explain: _____

Are you currently taking any prescription/over the counter drugs Y or N

Please list each one: _____

_____

Have you ever had any of the following diseases or medical problems?

Y	N	Alcohol Abuse	Y	N	Hepatitis
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Bones/Joints	Y	N	HIV+/AIDS
Y	N	Artificial Valves	Y	N	Hospitalized for any reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse MVP
Y	N	Colitis	Y	N	Psychiatric Problems
Y	N	Congenital Heart Defect	Y	N	Radiation Treatment
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Difficulty Breathing	Y	N	Seizures
Y	N	Drug Abuse	Y	N	Severe/Frequent Headaches
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy	Y	N	Sinus Problems
Y	N	Fever Blisters-Cold Sores	Y	N	Smoke
Y	N	Glaucoma	Y	N	Stroke
Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery/Pacemaker	Y	N	Use Chewing Tobacco
Y	N	Hemophilia/Anemia	Y	N	Blood Thinners

For Women:
Are you Pregnant? Y N
If yes, Week #: _____
Are you Nursing? Y N

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Sulfa
Y	N	Erythromycin	Y	N	Codeine	Y	N	Other

Please list any other drugs you are allergic to: _____

Emergency Contact Name: _____ Phone #: _____

Patient Signature: _____ ☐ Patient ☐ Legal Guardian

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