Janis Moriarty, DMD

Medical History Update

As a policy we require our patients to update their medical history in its entirety annually as it is required by the MA Board of Registration in Dentistry. All information is kept confidential.

Patient Name: _____ **Birthdate:** ____/____/____
(Last) (First) (Initial)

Address: _____ **City, State & Zip:** _____

(H) Phone #: _____ **Cell #:** _____ **Business Phone:** _____

E-mail Address: _____

Sex: ___ M ___ F Age: _____ Status: ___Single ___Married ___Widowed ___Separated ___ Divorced

Has your Dental Insurance changed since your last visit with us? ___ NO ___ YES

If YES, please see the front desk receptionist.

Notify in case of an emergency: _____
Name Phone# Relationship to patient

Physician's Name & Phone #: _____

Any serious illnesses or operations? ____ Y ____ N If YES, describe_____

Are you required to take an antibiotic before certain dental procedures? (Ex: Joint replacement)
____ Y ____N If YES, describe & did you take it for today's visit: _____
If there has been a change that conflicts with our practices and you no longer require premedication we require a note from your physician or surgeon to keep on file before you can be treated.

Do you take Coumadin or any type of blood thinner presently? ____ Y ____ N

If YES, date blood levels last checked: _____ INR Level:_____ If you do not have this information please see the front desk.

WOMEN: Are you pregnant: __Y __N Nursing: __Y __N Taking birth control pills? __Y __N

CHECK Y for Yes and N for NO for the following:

__Y __N AIDS/HIV
__Y __N Anaphylaxis
__Y __N Anemia
__Y __N Arthristis,Rheumatism
__Y __N Artificial heart values
__Y __N Artificial joints
__Y __N Asthma
__Y __N Atopic (allergy prone)
__Y __N Back problems
__Y __N Blood disease
__Y __N Cancer
__Y __N Chemical dependency
__Y __N Chemotherapy
__Y __N Cough, persistent
__Y __N Cough up blood
__Y __N Circulatory problems
__Y __N Diabetes
__Y __N Dry Mouth
__Y__N Epilepsy
__Y __N Excessive Urination
__Y __N Food allergies
__Y __N Gastrointestinal Disease
__Y __N G.E. Reflux
__Y __N Glaucoma
__Y __N Headaches/Migraines
__Y __N Heart murmur
__Y __N High Blood Pressure
__Y __N Heart Surgery
__Y __N Hemophilia
__Y __N Herpes
__Y __N Hepatitis
__Y __N Jaw Pain
__Y __N Kidney disease
__Y __N Liver disease
__Y __N Mitral Valve Prolapse
__Y __N Pacemaker
__Y __N Psychiatric care
__Y __N Rapid weight loss/gain
__Y __N Radiation treatment
__Y __N Respiratory disease
__Y __N Seizure Disorder
__Y __N Shingles
__Y __N Shortness of breath
__Y __N Sinus trouble
__Y __N Skin rash
__Y __N Stroke
__Y __N Surgical Implants
__Y __N Swelling feet/ankles
__Y __N Thyroid disease
__Y __N Tobacco habit
__Y __N Tuberculosis
__Y __N Venereal disease

If you have your medications and allergies listed on a separate piece of paper we will be happy to make a copy to save you time.

List medications you are currently taking, if any:
_____
_____

List drug or material allergies, if any:
_____
_____

PATIENT SIGNATURE: _____ **DATE**: _____

YEAR: _____