



CNA HealthPro

Patient Records: Medical History

A number of malpractice lawsuits are filed each year by patients who claim the dental treatment they received led to a complication or bad result, as a consequence of an existing medical condition which contributed to the poor outcome. The patients claim that, although their dentist did not know of the condition, he or she should have been aware of it through the patient's medical history. Finally, these patients maintain their dentist is negligent because the dentist failed to recognize the condition and prevent the complication or bad result.

Examples of medical complications include bacterial endocarditis in a patient with a history of rheumatic fever, an anaphylactic reaction in a penicillin-allergic patient, and a severe infection in a diabetic or immunosuppressed patient. To defend against these types of claims, dentists should record and maintain a proper medical history for each patient.

Why the medical history is important

A patient's medical history should be taken before treatment begins. The history will protect the patient and help you:

- Obtain medical information you need to aid in diagnosis
- Discover medical conditions that may influence your dental services
- Discover past or present medical care that may influence your treatment plan

How to obtain and document the medical history

The medical history should be consistently recorded from patient to patient. By following the same procedure each time, you can obtain important information and avoid common mistakes.

Many dentists use a history information form on which the patient can circle a "yes" or "no" answer next to specific medical questions. Extra space is often provided for the patient to elaborate. For example:

Do you have any allergies? Yes { } No { }

If yes, please specify: _____

After the medical history is complete, the patient (or the patient's guardian, when appropriate) should sign and date the form. The treating dentist should also sign and date the form. Review the form with the patient to ensure all questions were understood and properly answered. This form now becomes a part of the patient's permanent dental record.

With minor patients, verbally review the medical history form with both the guardian and patient in separate conversations. (A parent may not be aware of a child's drug use or pregnancy, for example.)

Examples of medical conditions and care

Here are some examples of medical conditions and medical care that may alter your treatment plan:

- Immunosuppression
- Pregnancy
- Use of oral contraceptives
- Hormonal imbalances
- Diabetes
- Allergies
- Hypertension
- Cardiac conditions
- Blood dyscrasias
- Prosthetic valves and joints

Note, this is not intended to be a complete list of conditions for which you should seek additional information from the patient or the patient's physician.

How medical conditions alter dental treatment

The medical history identifies any problems which enter into the evaluation of a dental procedure or treatment plan. A completed history can make you aware of health hazards the patient may present and the effects which your treatment might produce in a given patient. For example:

- Anesthetics containing epinephrine may be contraindicated in hypertensive patients
- Prophylactic antibiotics may be indicated in patients with prosthetic valves and joints, a history of rheumatic fever, congenital heart murmurs, etc.
- Antibiotics may decrease the effectiveness of birth control pills
- Hormonal imbalances or immunosuppression may warrant a prescription for an antibiotic following certain dental procedures

When to update the medical history

You should complete a full medical history on all new patients. Review the medical history with the patient to make sure all conditions are documented. (Advancements in scientific knowledge may necessitate additions to existing forms to keep histories current.) You and the patient should both sign and date the form. Enter new information in the patient's permanent record whenever the history is reviewed.

Complete and current medical histories are essential preventive measures. Update the information at every office visit and document changes in the patient's file. Review and discuss the conditions with the patient (or the guardian, when appropriate) before proceeding with dental treatment.

Obtaining and recording a medical history for each patient is an important professional and legal obligation. The time you take to fulfill this responsibility will help ensure proper patient care and if necessary, aid in the defense of a malpractice lawsuit.

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