



CNA HealthPro

Updating the Medical History

An accurate and current medical history is an essential tool in providing quality dental care. It also protects both the patient and you from unnecessary risks. Failure to obtain, update, and investigate the patient's medical history have all been alleged in professional liability claims against dentists.

The primary purpose of a written medical history is to refresh your memory of the patient's physical status, reducing the chance of injury. By taking and regularly updating the patient's medical history, you can

- prevent drug interactions
- spot oral manifestations of systemic diseases or pharmacotherapy
- better manage patients with such medical conditions as heart disease, high blood pressure and diabetes

Evidence of a dentist's lack of diligence in asking for and distributing vital medical information would strongly support a patient's claim of professional negligence.

Good dentistry depends upon always having the most current information about your patients' health and checking their medical history before beginning treatment. The following steps should, therefore, be taken at *each and every visit*:

- Review the written medical history.
- Ask your patient, "Have you had any changes in your medical history since your last visit?"
- Check the patient's current medications and dietary supplements.

Any affirmative responses or changes in medication or supplement regimens should be noted in the patient's chart. An example would be "MHR: now taking Dicumarol 180 mg daily, up from 100 mg. Remainder neg."

At least annually, ask patients to review their most recent medical history questionnaire and note in writing on the form any changes that have occurred since it was originally completed. Have the patient initial and date the changes (if any), then re-sign and date the form near the patient's original signature. After the patient has reviewed the form, review it orally with the patient, then sign and date it yourself. Any changes that come to light on the questionnaire should also be documented in the progress notes section of the patient record. Also, visually assess the patient, noting physical and/or psychological problems that might not be evident from the written history. When the form becomes crowded with notations, it is time to ask the patient to complete a new questionnaire.

At recall visits when the patient has *not* filled out or revised a medical history questionnaire, ask the following questions:

Since your last dental visit,

- Have you seen a physician or other healthcare professional for any treatment or consultation?
- Have you suffered any illness or injury?
- Have you stopped, started or changed any prescription or over-the-counter medication or dietary supplement?

Proper documentation is essential after every inquiry, even if there are no changes. Entries like "Reviewed MH, pt. reports no changes" or "MHR neg" indicate that the health history was reviewed and found unchanged since the last visit.

Important health history information should be displayed clearly and conspicuously in the dental record, so that all providers can be aware of drug interactions, allergies, communicable diseases and other potential complications. However, do not place medical alert information on the outside of a patient chart, as this could be construed as a violation of patient confidentiality.

The importance of gathering complete, accurate health history information cannot be overstated. Failing to obtain and distribute vital data endangers patients and increases the liability risk for you and your staff. Remember, all it takes is a small oversight to cause significant patient injury.

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