Medical History continued...

Your current physical health is: ❑ **Good** ❑ **Fair** ❑ **Poor**

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain: ______________________

Are you taking any prescription/over-the-counter drugs?

❑ No ❑ Yes If yes, please list: ______________

For Women: Are you taking birth control pills? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes Week #: ___________

Are you nursing? ❑ No ❑ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No		Yes	No	
❑	❑	Heart Attack/Stroke	❑	❑	Epilepsy/Seizures/Fainting
❑	❑	Heart Murmur	❑	❑	Diabetes/Tuberculosis (TB)
❑	❑	Rheumatic Fever	❑	❑	Drug/Alcohol Abuse
❑	❑	Artificial Valves	❑	❑	Hemophilic/Abnormal Bleeding
❑	❑	Heart Surgery/Pacemaker	❑	❑	Ulcers/Colitis
❑	❑	Mitral Valve Prolapse	❑	❑	Anemic/Radiation Treatment
❑	❑	Congenital Heart Defect	❑	❑	Asthma/Arthritis
❑	❑	High/Low Blood Pressure	❑	❑	Difficulty Breathing
❑	❑	Cancer/Chemotherapy	❑	❑	Hospitalized for Any Reason
❑	❑	Shingles	❑	❑	Hepatitis
❑	❑	Kidney Problems	❑	❑	HIV+/AIDS
❑	❑	Artificial Bones/Joints	❑	❑	Blood Transfusion
❑	❑	Sinus Problems	❑	❑	Emphysema/Glaucoma
❑	❑	Fever Blisters			
❑	❑	Severe/Frequent Headaches			
❑	❑	Psychiatric Problems			

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

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Dental Anesthetics
❑	❑	Aspirin	❑	❑	Codeine
❑	❑	Erythromycin	❑	❑	Latex
❑	❑	Tetracycline	❑	❑	Other ___________

Dental History...

Why have you come to the dentist today? ______________________

____

Are you currently in pain? ❑ No ❑ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❑ No ❑ Yes

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ No ❑ Yes

Do your gums ever bleed? ❑ No ❑ Yes

How many times a week do you floss? ___________

How many times a day do you brush? ___________

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Acknowledgement

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Lakeside Dental of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

______________________ ___________

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you

for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL BY OSHA, THE CDC, AND THE ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Initials _______ Date _________

Doctor's Comments: ______________________

____

MEDICAL HISTORY UPDATE

1) Date _______ **Comments** ______________________ **Signature** _________

2) Date _______ **Comments** ______________________ **Signature** _________

3) Date _______ **Comments** ______________________ **Signature** _________