LAKEVILLE ADVANCED DENTAL CARE

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

Please answer completely to the best of your knowledge. Health problems that you have or medications that could have an important interrelationship with the dentistry you will receive. Thank you.

Are you under a physician's care?	Yes	No	If yes: _____
Have you recently been hospitalized or had a major operation?	Yes	No	If yes: _____
Are you currently taking any blood thinners such as Aspirin, Warfarin, Coumadin?	Yes	No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes: _____
Are you taking any other medications, herbal supplements, vitamins, etc?	Yes	No	If yes: _____
Have you ever been told to pre medicate prior to dental appointments?	Yes	No	If yes: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes: _____
Are you on special diet?	Yes	No	If yes: _____
Do you use tobacco, including e-cigs?	Yes	No	If yes: _____
Do you use recreational substances?	Yes	No	If yes: _____

Women: Are you…

Pregnant/Trying to get pregnant? _____ Nursing? _____ Taking oral contraceptives? _____

Are you allergic to any of the following?

Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____

Metal _____ Latex _____ Sulfa Drugs _____ Local Anesthetics _____

Do you have any other allergies? Yes No If yes, please list _____

_____

MEDICAL HISTORY CONTINUED

Do you have or have you ever had, any of the following?

AIDS/HIV Positive	Yes	No	Hemophilia	Yes	No
Alzheimer's Disease	Yes	No	Hepatitis A	Yes	No
Anaphylaxis	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Angina	Yes	No	High Blood Pressure	Yes	No
Epilepsy or Seizures	Yes	No	Scarlet Fever	Yes	No
Excessive Bleeding	Yes	No	Shingles	Yes	No
Excessive Thirst	Yes	No	Sickle Cell Disease	Yes	No
Fainting Spells/Dizziness	Yes	No	Sinus Trouble	Yes	No
Frequent Cough	Yes	No	Spina Bifida	Yes	No
Leukemia	Yes	No	Breathing Problems	Yes	No
Liver Disease	Yes	No	Bruise Easily	Yes	No
Swelling of Limbs	Yes	No	Glaucoma	Yes	No
Thyroid Disease	Yes	No	Hay Fever	Yes	No
Tonsillitis	Yes	No	Heart Attack/Failure	Yes	No
Tuberculosis	Yes	No	Heart Murmur	Yes	No
Tumors or Growths	Yes	No	Heart Pacemaker	Yes	No
Ulcers	Yes	No	Heart Trouble/Disease	Yes	No
Yellow Jaundice	Yes	No	Radiation Treatments	Yes	No
Cortisone Medicine	Yes	No	Recent Weight Loss	Yes	No
Diabetes	Yes	No	Renal Dialysis	Yes	No
Drug Addiction	Yes	No	Rheumatic Fever	Yes	No
Easily Winded	Yes	No	Arthritis/Gout	Yes	No
Emphysema	Yes	No	Artificial Heart Valve	Yes	No
High Cholesterol	Yes	No	Artificial Joints	Yes	No
Hives or Rash	Yes	No	Asthma	Yes	No
Hypoglycemia	Yes	No	Blood Disease	Yes	No
Irregular Heartbeat	Yes	No	Blood Transfusion	Yes	No
Kidney Problems	Yes	No	Frequent Headaches	Yes	No
Stomach/Intestinal Disease	Yes	No	Low Blood Pressure	Yes	No
Stroke	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Mitral Valve Prolapse	Yes	No
Chemotherapy	Yes	No	Osteoporosis	Yes	No
Chest Pains	Yes	No	Pain in Jaw Joints	Yes	No
Cold Sores/Fever Blisters	Yes	No	Parathyroid Disease	Yes	No
Congenital Heart Disorder	Yes	No	Psychiatric Care	Yes	No
Convulsions	Yes	No	Depression	Yes	No

Have you ever had any serious illness not listed above? Yes No

If yes: _____

Comments:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent Or Guardian **Date**