

Lanewood Dental Group

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

**Thank you for answering the following questions.**

Are you currently under a physician's care now? Yes/ No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes/ No

If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes/ No

If yes, please explain: \_\_\_\_\_

Are you taking medications, pills, or drugs? Yes/ No

If yes, please explain: \_\_\_\_\_

Do you take/ or have taken, Phen-Fen or Redux? Yes/ No Are you on a special diet? Yes/ No

**For Women:** Pregnant /Trying to get pregnant- Yes/ No Taking oral contraceptives: Yes/ No Nursing: Yes/ No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other - If yes, please explain: \_\_\_\_\_

**Do you have, or have you had, any of the following? Please circle Yes or No.**

<b>AIDS/HIV:</b> Yes/ No	<b>Controlled Substance Use:</b> Yes/No	<b>Hepatitis A:</b> Yes/ No	<b>Renal Dialysis:</b> Yes/ No
<b>Alzheimer's:</b> Yes/ No	<b>Convulsions:</b> Yes/ No	<b>Hepatitis B/ C:</b> Yes/ No	<b>Rheumatic Fever:</b> Yes/ No
<b>Anaphylaxis:</b> Yes/ No	<b>Cortisone Medicine:</b> Yes/ No	<b>Herpes/ Cold Sores:</b> Yes/ No	<b>Rheumatism:</b> Yes/ No
<b>Anemia:</b> Yes/ No	<b>Diabetes:</b> Yes/ No	<b>High Blood Pressure:</b> Yes/ No	<b>Scarlet Fever:</b> Yes/ No
<b>Angina:</b> Yes/ No	<b>Drug Addiction:</b> Yes/ No	<b>Hives/ Rash:</b> Yes/ No	<b>Shingles:</b> Yes/ No
<b>Any Immune Deficiency:</b> Yes/ No	<b>Easily Winded:</b> Yes/ No	<b>Hypoglycemia:</b> Yes/ No	<b>Sickle Cell Disease:</b> Yes/ No
<b>Arthritis/ Gout:</b> Yes/ No	<b>Emphysema:</b> Yes/ No	<b>Irregular Heartbeat:</b> Yes/ No	<b>Sinus Trouble:</b> Yes/ No
<b>Artificial Heart Valve:</b> Yes/ No	<b>Epilepsy/ Seizures:</b> Yes/ No	<b>Kidney Problems:</b> Yes/ No	<b>Spina Bifida:</b> Yes/ No
<b>Artificial Joint:</b> Yes/ No	<b>Excessive Bleeding:</b> Yes/ No	<b>Leukemia:</b> Yes/ No	<b>Sexual Transmitted Disease:</b> Yes/ No
<b>Asthma:</b> Yes/ No	<b>Excessive Thirst:</b> Yes/ No	<b>Liver Disease:</b> Yes/ No	<b>Stroke:</b> Yes/ No
<b>Blood Disorder/Clotting:</b> Yes/ No	<b>Fainting/ Dizziness:</b> Yes/ No	<b>Low Blood Pressure:</b> Yes/ No	<b>Swelling of Limbs:</b> Yes/ No
<b>Blood Transfusion:</b> Yes/ No	<b>Frequent Cough:</b> Yes/ No	<b>Lung Disease:</b> Yes/ No	<b>Thyroid Disease:</b> Yes/ No
<b>Breathing Problem:</b> Yes/ No	<b>Frequent Headaches:</b> Yes/ No	<b>Mitral Valve Prolapse:</b> Yes/ No	<b>Tobacco Use:</b> Yes/ No
<b>Bruise Easily:</b> Yes/ No	<b>Gastro Intestinal Disease:</b> Yes/ No	<b>Multiple Sclerosis:</b> Yes/ No	<b>Tonsillitis:</b> Yes/ No
<b>Cancer:</b> Yes/ No	<b>Glaucoma:</b> Yes/ No	<b>Muscular Dystrophy:</b> Yes/ No	<b>Tuberculosis:</b> Yes/ No
<b>Cardiovascular Disease:</b> Yes/ No	<b>Hay Fever:</b> Yes/ No	<b>Osteoporosis:</b> Yes/ No	<b>Tumors/ Growths:</b> Yes/ No
<b>Chemotherapy:</b> Yes/ No	<b>Heart Attack/Failure:</b> Yes/ No	<b>Osteopenia:</b> Yes/ No	<b>Ulcers:</b> Yes/ No
<b>Chest Pains:</b> Yes/ No	<b>Heart Murmur:</b> Yes/ No	<b>Pain in Jaw Joints:</b> Yes/ No	<b>Unexplained Weight Loss:</b> Yes/ No
<b>Congenital Heart Disease:</b> Yes/ No	<b>Heart Pacemaker:</b> Yes/ No	<b>Parathyroid Disease:</b> Yes/ No	<b>Yellow Jaundice:</b> Yes/ No
	<b>Heart Trouble/Disease:</b> Yes/No	<b>Psychiatric Care:</b> Yes/ No	
	<b>Hemophilia:</b> Yes/ No	<b>Radiation Treatment:</b> Yes/ No	

Have you ever had any serious illness not listed above?

If yes please explain: \_\_\_\_\_

*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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.*