

HEALTH HISTORY

First Name	Last N	lame_	MI Pn#() Rirth Date		
What is your chief Dental concern?			Birth Date	/ /	
List all medicines you are taking:					
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		Ec	or Office Use Only		
		10	in Office Ose Only		
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		- C 41-	following? (Check Ves/No for each question.)		
Do you have, or have you had	1 any	OI the	e following? (Check Yes/No for each question.)	Yes	No
Allergies to medications (Please List):			Tuberculosis date		
Affergies to medications (Flease List).			Respiratory Disease		
			Do you currently use tobacco?		
			Do you have a history of tobacco use?		
Ill effects from codeine, aspirin, latex,			Asthma		
anesthetics, novocaine, antibiotics			Bronchitis		
Do you take Blood Thinners?			Pneumonia		
High blood pressure			Emphysema		
Low blood pressure			Pins, Screws or Plates location		
Heart Condition			Joint Replacement locationdate		
Pacemaker			Thyroid problems		
			Ear Infections		
Angina (Chest Pain)			Sinus trouble		
Nitro patches Stroke date			Lupus Erythematosis		
Prosthetic artery replacement			Growth/Tumor/Cancer		
Prosthetic heart valves (Artificial)			Radiation treatment locationdate		
Heart Attack(s) date			Chemotherapy locationdate		
By-Pass surgery date			Glaucoma		
Cardiac Stent			Cold Sores (Herpes)		
			Venereal Disease		
Diabetes			Periodontal/gum surgery date		
Hypoglycemia			Prolonged bleeding tendency		
Hepatitis Liver Disease			Are you pregnant? due date		
			Excessive emotional stress		
Osteoporosis			Frequent headaches/migraines		
HIV/AIDS Blood Transfusion(s) date			Arthritis/sore joints		
Kidney Disease			("TMJ") Jaw Joint Problems		
Are you currently or	have	you e	ver taken any of the following medications:		
D' Lambanata or Alandranate ev Fo	osama	ax. Sl	kelid. Zometa, Prolin, Risendronate ex Actonel, Ib	andro	nate
ex Roniva, Bonefos, Zolendronic A	cid e	x Rec	elast, Pamidronote ex Aredia, Etidronate ex Didro	nel, et	c.
Madical problems not listed above					
Provious Surgarias/Data(s)					
Signature			Date		
			ng Lakeside Family Dental Care!		
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