

## **HEALTH HISTORY**

First Name Last Name What is your chief Dental concern? List all medicines you are taking:			Birth Date	te//	
		For O	office Use Only		
			•		
Do you have, or have you had			ollowing? (Check Yes/No for each question.)		
Allowains to modinations (Plance List):		No	Tuberculosis date	Yes	No
Allergies to medications (Please List):			Respiratory Disease		
			Do you currently use tobacco?		
			Do you have a history of tobacco use?		
Ill effects from codeine, aspirin, latex,			Asthma/Bronchitis/Pneumonia		
anesthetics, novocaine, antibiotics			<b>Emphysema</b>		
High blood pressure			Pins, Screws or Plates location		
Low blood pressure			Joint Replacement location date		
Heart Condition			Thyroid problems		
Pacemaker			Ear Infections		
Angina (Chest Pain)			Sinus trouble		
Nitro patches			Lupus Erythematosis		
Stroke			Growth/Tumor/Cancer		
Prosthetic artery replacement			Radiation treatment		
Prosthetic heart valves (Artificial)			Chemotherapy		
Heart Attack(s) date			Glaucoma		
By-Pass surgery date			Cold Sores (Herpes)		
Cardiac Stent			Venereal Disease		
Diabetes			Periodontal/gum surgery date		
Hypoglycemia			Prolonged bleeding tendency		
Hepatitis			Blood thinners		
Liver Disease			Are you pregnant?		
Osteoporosis			<b>Excessive emotional stress</b>		
HIV/AIDS			Frequent headaches/migraines		
Blood Transfusion(s) date			Arthritis/sore joints		
Kidney Disease			("TMJ") Jaw Joint Problems		
			n any of the following medications:		
<u>Bisphosphonate ex Fosamax, Sk</u>	elid,	Zometa	a, Actonel, Aredia, Boniva, Bonefos, etc.		
Medical problems not listed above					
Previous Surgeries/Date(s)					
Signature			Date		
Thank you f	for ch	oosing	Lakeside Family Dental Care!		
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			CR# INITIALS		
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