MEDICAL HISTORY

Hilary M. Lane, DDS

Patient Name _____ Birthdate _____

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Please circle YES or NO, and if YES please explain:

Are you under a physician's care now? YES NO _____

Have you ever been hospitalized or had a major operation? YES NO _____

_____

Do you use tobacco? YES NO _____

Do you use controlled substances? YES NO _____

Women: Are you pregnant/trying to get pregnant? YES NO
Taking oral contraceptives? YES NO
Nursing? YES NO

List any medications you are taking _____

Please check if you are allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other _____

Check any of the following you have or had:

☐ AIDS/HIV positive
☐ Alzheimer's disease
☐ Anaphylaxis
☐ Anemia
☐ Angina/Chest pain
☐ Arthritis
☐ Artificial heart valve
☐ Artificial Joint
☐ Asthma
☐ Blood disease
☐ Blood transfusion
☐ Breathing problems
☐ Bruise easily
☐ Cancer
☐ Chemotherapy
☐ Cold Sores
☐ Congenital Heart Disorder
☐ Cortisone medication
☐ Diabetes
☐ Drug addiction
☐ Excessive bleeding
☐ Fainting
☐ Spells/Dizziness
☐ Frequent cough
☐ Frequent diarrhea
☐ Frequent headaches
☐ Glaucoma
☐ Hay fever
☐ Heart attack
☐ Heart pacemaker
☐ Heart transplant
☐ Heart stents
☐ Infective endocarditis
☐ Hemophilia
☐ Hepatitis A, B or C
☐ Herpes
☐ High blood pressure
☐ Hives/rash
☐ Hypoglycemia
☐ Kidney problems
☐ Leukemia
☐ Liver disease
☐ Low blood pressure
☐ Lung disease
☐ Pain in jaw joints
☐ Psychiatric care
☐ Radiation treatment
☐ Recent weight loss
☐ Renal dialysis
☐ Shingles
☐ Sickle cell disease
☐ Sinus trouble
☐ Stomach disease
☐ Stroke
☐ Thyroid disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Ulcers

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____ Date _____