LAWSON
family dental

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Medical History

Patient Name _____ Date of Birth _____ Date Created _____

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 medication 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 under a physician's care now? ○Yes ○No If yes _____
Have you ever been hospitalized or had a major operation? ○Yes ○No If yes _____
Have you ever had a serious head or neck injury? ○Yes ○No If yes _____
Are you taking any medications, pills, or drugs? ○Yes ○No If yes _____
Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No If yes _____
Are you on a special diet? ○Yes ○No
Do you use tobacco? ○Yes ○No
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

Other? If yes _____
Do you use controlled substances? ○Yes ○No If yes _____

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

AIDS/HIV Positive ○Y ○N	Diabetes ○Y ○N	Hepatitis B or C ○Y ○N	Rheumatic Fever ○Y ○N
Alzheimer's Disease ○Y ○N	Drug Addiction ○Y ○N	Herpes ○Y ○N	Rheumatism ○Y ○N
Anaphylaxis ○Y ○N	Easily Winded ○Y ○N	High Blood Pressure ○Y ○N	Scarlet Fever ○Y ○N
Anemia ○Y ○N	Emphysema ○Y ○N	High Cholesterol ○Y ○N	Shingles ○Y ○N
Angina ○Y ○N	Epilepsy or Seizures ○Y ○N	Hives or Rash ○Y ○N	Sickle Cell Disease ○Y ○N
Arthritis/Gout ○Y ○N	Excessive Bleeding ○Y ○N	Hypoglycemia ○Y ○N	Sinus Trouble ○Y ○N
Artificial Heart Valve ○Y ○N	Excessive Thirst ○Y ○N	Irregular Heartbeat ○Y ○N	Spina Bifida ○Y ○N
Artificial Joint ○Y ○N	Fainting Spells/Dizziness ○Y ○N	Kidney Problems ○Y ○N	Stomach/ ___ ○ ○
Asthma ○Y ○N	Frequent Cough ○Y ○N	Leukemia ○Y ○N	Intestinal Disease ○Y ○N
Blood Disease ○Y ○N	Frequent Diarrhea ○Y ○N	Liver Disease ○Y ○N	Stroke ○Y ○N
Blood Transfusion ○Y ○N	Frequent Headaches ○Y ○N	Low Blood Pressure ○Y ○N	Swelling of Limbs ○Y ○N
Breathing Problems ○Y ○N	Genital Herpes ○Y ○N	Lung Disease ○Y ○N	Thyroid Disease ○Y ○N
Bruise Easily ○Y ○N	Glaucoma ○Y ○N	Mitral Valve Prolapse ○Y ○N	Tonsillitis ○Y ○N
Cancer ○Y ○N	Hay Fever ○Y ○N	Osteoporosis ○Y ○N	Tuberculosis ○Y ○N
Chemotherapy ○Y ○N	Heart Attack/Failure ○Y ○N	Pain in Jaw Joints ○Y ○N	Tumors or Growths ○Y ○N
Chest Pains ○Y ○N	Heart Murmur ○Y ○N	Parathyroid Disease ○Y ○N	Ulcers ○Y ○N
Cold Sores/Fever Blisters ○Y ○N	Heart Pacemaker ○Y ○N	Psychiatric Care ○Y ○N	Venereal Disease ○Y ○N
Congenital Heart Disorder ○Y ○N	Heart Trouble/Disease ○Y ○N	Radiation Treatments ○Y ○N	Yellow Jaundice ○Y ○N
Convulsions ○Y ○N	Hemophilia ○Y ○N	Recent Weight Loss ○Y ○N	
Cortisone Medicine ○Y ○N	Hepatitis A ○Y ○N	Renal Dialysis ○Y ○N	

Have you ever had any serious illness not listed? ○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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____
Date _____