

Lincoln Heights Dental Center, P. S.

Name _____ Date _____

IMPORTANT Please read the following carefully before completing the Medical History

Over the past few decades, medical science has developed many new drugs and procedures that have enhanced and lengthened the lives of millions. Many of these medical procedures have a direct bearing on the dental treatment provide in this office. To protect your health, we ask you to be as thorough as possible when answering the following questions. All information is kept completely confidential.

MEDICAL HISTORY

Medical physician's name _____ Date of last physical _____

Reason & date of last medical exam _____

List any in-patient and/or out-patient surgical treatment _____

List any hospitalization and/or serious illness _____

Please check the appropriate answer next to the following conditions

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Cold sore/Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/MVP	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Tendency
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Arterial Stent	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental disorders
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Internal Automatic Defibulator	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease

List any medications you are taking including both prescription AND non prescription drugs _____

Check any of the following medications you have taken in the last six months:

- | | | |
|--|---|---|
| <input type="checkbox"/> Cortisone Drugs | <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Tranquillizers |
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Sedatives |

Are you allergic to or suffer any ill effects from:

- | | | |
|---|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Anesthetic |
| <input type="checkbox"/> Aspirin/NSAIDS | <input type="checkbox"/> Household Bleach | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Sulfites (i.e. red wine) | <input type="checkbox"/> Other |

WOMEN ONLY: Are you pregnant? _____ How many months? _____ Are you breast feeding _____

**FOR OFFICIAL
USE ONLY**

BP _____

The above information is true to the best of my knowledge.

_____ Date _____

Patient or parent/guardian signature