LAKELAND FAMILY DENTAL | MEDICAL HISTORY

Patient Name:____ Date of Birth: ______________________

1.) Have you been in the care of a medical doctor during the past 2 years? ....YES NO
If yes, why____
If no, date of last routine physical:____
Physician's name & address:____

2.) Are you taking any medications or supplements, prescription or otherwise? ....YES NO
If yes, please list names & dosages:____
____

3.) Are you allergic to/have any problems with any medications, substances, or metals?...................................YES NO
If yes, please list____

4.) Have you been hospitalized within the last 5 years, or ever had a serious illness or major surgery?.........YES NO
If yes, please explain____

5.) Indicate which of the following you previously or currently have been diagnosed with by circling Yes or No:

Heart disease......................	(Y / N)	Kidney problems....	(Y / N)	STI/STDs.........................	(Y / N)
Heart attack........................	(Y / N)	Ulcers........................	(Y / N)	HIV positive.....................	(Y / N)
Chest pain...........................	(Y / N)	Diabetes..................	(Y / N)	AIDS................................	(Y / N)
Congenital heart disease.....	(Y / N)	Thyroid problems...	(Y / N)	Cold sores.........................	(Y / N)
Heart murmur.....................	(Y / N)	Glaucoma..................	(Y / N)	Liver disease.....................	(Y / N)
High/low blood pressure...	(Y / N)	Emphysema............	(Y / N)	Excessive bleeding............	(Y / N)
Mitral valve prolapse..........	(Y / N)	Tuberculosis...........	(Y / N)	Sickle cell anemia..............	(Y / N)
Artificial heart valve...........	(Y / N)	Asthma.....................	(Y / N)	Neurological disorders.....	(Y / N)
Pacemaker..........................	(Y / N)	Seasonal allergies....	(Y / N)	Epilepsy or seizures.........	(Y / N)
Rheumatic fever..................	(Y / N)	Radiation therapy...	(Y / N)	Fainting or dizzy spells.....	(Y / N)
Arthritis/rheumatism..........	(Y / N)	Chemotherapy.........	(Y / N)	General anxiety.................	(Y / N)
Stroke.................................	(Y / N)	Latex sensitivity......	(Y / N)	Psychiatric treatment.......	(Y / N)
Restricted diet.....................	(Y / N)	Stomach problems...	(Y / N)	Tobacco use.......................	(Y / N)
Artificial joints/prosthesis..	(Y / N)	Hepatitis A/B/C.......	(Y / N)	type/how long_________	

6.) Please elaborate on any "yes" answers above, or explain any disease, condition, or problem not listed above:____
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7.) WOMEN: Are you taking birth control pills (Y / N), nursing (Y / N), or pregnant (Y / N)?

I understand the above information is necessary to provide me with dental care in a safe, efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to contact the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

PLEASE INFORM OUR EMPLOYEES OF ANY CHANGES IN YOUR INSURANCE INFORMATION

____ ____
(Patient/Guardian Signature) (Date) (Dentist's signature) (Date)