



HEALTH HISTORY

First Name Last Name MI Ph# () - Birth Date / /

What is your chief Dental concern?

List all medicines you are taking:

For Office Use Only

Do you have, or have you had any of the following? (Check Yes/No for each question.)

Table with 4 columns: Question, Yes, No, Yes, No. Rows include Allergies to medications, Tuberculosis, Respiratory Disease, Do you currently use tobacco?, Do you have a history of tobacco use?, Asthma/Bronchitis/Pneumonia, Emphysema, Pins, Screws or Plates, Joint Replacement, Thyroid problems, Ear Infections, Sinus trouble, Lupus Erythematosus, Growth/Tumor/Cancer, Radiation treatment, Chemotherapy, Glaucoma, Cold Sores (Herpes), Venereal Disease, Periodontal/gum surgery, Prolonged bleeding tendency, Blood thinners, Are you pregnant?, Excessive emotional stress, Frequent headaches/migraines, Arthritis/sore joints, ("TMJ") Jaw Joint Problems.

Are you currently or have you ever taken any of the following medications: Bisphosphonate ex Fosamax, Skelid, Zometa, Actonel, Aredia, Boniva, Bonefos, etc.

Medical problems not listed above

Previous Surgeries/Date(s)

Signature Date

Thank you for choosing Lakeside Family Dental Care!