Lakeside
FAMILY DENTAL CARE

HEALTH HISTORY

John K. Grothe, D.M.D., P.A.
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First Name_____ **MI**____ **Last Name**_____ **Ph# ( ) -**
What is your chief Dental concern _____**Birth Date / /**
List all medications you are taking _____
_____
_____
_____

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

	Yes	No		Yes	No
Allergies to Medications (List)	☐	☐	**Kidney Disease**	☐	☐
_____			**Respiratory Disease**	☐	☐
_____			**Do you currently use tobacco**	☐	☐
_____			**Do you have a history of tobacco use**	☐	☐
Effect from Codeine Aspirin Latex	☐	☐	**Asthma / Bronchitis / Pneumonia**	☐	☐
Anesthetics Novocain Antibiotics	☐	☐	**Emphysema**	☐	☐
High / Low Blood Pressure	☐	☐	**Tuberculosis date** _____	☐	☐
Prolonged Bleeding / Blood Thinner	☐	☐	**Pins, Screws, or Plates location** _____	☐	☐
Heart Condition	☐	☐	**Joint Replacement date**_____**location**_____	☐	☐
Mitral Valve Prolapse	☐	☐	**Thyroid Problems**	☐	☐
Pacemaker	☐	☐	**Ear Infections**	☐	☐
Angina Chest Pain	☐	☐	**Sinus Trouble**	☐	☐
Nitro Patches	☐	☐	**Lupus Erythematosus**	☐	☐
Prosthetic Artery Replacement	☐	☐	**Growth/Tumor/Cancer** _____	☐	☐
Prosthetic Heart Valves (Artificial)	☐	☐	**Radiation treatment**_____	☐	☐
Heart Attack(s) date _____	☐	☐	**Chemotherapy**	☐	☐
By-Pass Surgery date_____	☐	☐	**Glaucoma**	☐	☐
Cardiac Stent	☐	☐	**Cold Sores (Herpes)**	☐	☐
Heart Murmur	☐	☐	**STD Venereal Disease**	☐	☐
Rheumatic Fever / Scarlet Fever	☐	☐	**Periodontal / Gum Surgery date** _____	☐	☐
Stroke	☐	☐	**Arthritis / Sore Joints**	☐	☐
Diabetes	☐	☐	**Have you taken Fen-Phen**	☐	☐
Hypoglycemia	☐	☐	**Are you pregnant**	☐	☐
Hepatitis / Liver Disease	☐	☐	**Excessive emotional stress**	☐	☐
HIV / AIDS	☐	☐	**Frequent Headaches / Migraines**	☐	☐
Blood Transfusions date_____	☐	☐	**("TMJ") Jaw Joint Problems**	☐	☐
Are you currently or have you ever taken any medications for Osteoporosis Bisphosphonate,				☐	☐
Alendronate, Fosamax, Skelid, Zometa, Prolin, Risendronote, Actonel, Ibandronate, Aredia,				☐	☐
Boniva, Bonefos Zolendronic Acid, Reclast, Pamidronote, Aredia, Etidronate, Didronel, etc.				☐	☐

Medical problems not listed above_____
_____
_____
Previous Surgeries/Date(s) _____
_____
_____

Thank you for choosing Lakeside Family Dental Care!

Signature_____ **Date** _____

_____