Lampkin Family Dentistry

MEDICAL HISTORY

Today's Date _____

Name: First _____ Middle Initial: _____ Last: _____

In the following questions, circle yes or no (whichever applies). Your ansers are for our records only and will be considered confidential.

1. **Are you in good health? …….....YES NO**
2. **Has there been any change in your general health within the past year? ……YES NO**
3. **My last physical examination was on _____**
4. **Are you under the care of a physician? ……..…….. YES NO**
5. **The name, address and phone # of physician _____**
   _____
6. **Have you had any serious illness or operation within the past year? YES NO**
   a. **If so, please explain _____**
7. **Do you have or have you had any of the following diseases or problems?**
   a. **Damaged heart valves, artificial heart valves or congenital hear lesions……YES NO**
   b. **Rheumatic fever …….....YES NO**
   c. **Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, angina, low, blood pressure)…YES NO**
   d. **Have you had knee, hip or other joint replacements ……..YES NO**
   e. **Allergies, Sinus trouble, Hay Fever……..YES NO**
   f. **Asthma ……YES NO**
   g. **Diabetes …….. YES NO**
   h. **Fainting spells or seizures..... YES NO**
   i. **Arthritis.....YES NO**
   j. **Hepatitis, Jaundice, or liver disease ……YES NO**
   k. **Stomach ulcers…….. YES NO**
   l. **Kidney trouble …….. YES NO**
   m. **Tuberculosis ……YES NO**
   n. **Venereal disease or other communicable diseases …….. YES NO**
   o. **AIDS Auto Immune Deficiency Syndrome …….. YES NO**
8. **Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO**
9. **Do you have any blood disorder such as anemia? …….. YES NO**
10. **Have you had surgery or x-ray for treatment for a tumor, growth or other condition of your head or neck? …….....YES NO**
11. **Are you taking any drugs or medication? ……...YES NO**
    If so, what? _____
12. **Are you taking any of the following:**
    a. **Antibiotics or Sulfa drugs ……YES NO**
    b. **Anticoagulants (blood thinner) Coumadin …… YES NO**

PLEASE COMPLETE THE BACK

c. Medicine for high blood pressure .....YES NO
d. Cortisone .....YES NO
e. Tranquilizers .....YES NO
f. Antihistamines .....YES NO
g. Aspirin .....YES NO
h. Insulin, Tolbutamide (Orinase) or similar drug (for Diabetes) .....YES NO
i. Digitalis or Nitroglycerin drugs for heart trouble .....YES NO
j. Oral contraceptive or other hormone therapy .....YES NO
k. Other medications _____

13. Are you allergic or have you reacted adversely to
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics ..... YES NO
    c. Sulfa drugs ..... YES NO
    d. Barbiturates, sedatives, or sleeping pills ..... YES NO
    e. Aspirin ..... YES NO
    f. Iodine ..... YES NO
    g. Codeine or other narcotics ..... YES NO
    h. Other _____
14. Have you had any serious trouble associated with any previous dental treatment..... YES NO
    If so, explain

    _____

    _____
15. Do you have any disease, condition, or problem not listed above that you feel we should know about? If so, explain

    _____

    _____
16. Are you wearing contact lenses? ..... YES NO

WOMEN

17. Are you pregnant or nursing? .....YES NO

CHIEF DENTAL COMPLAINT:

_____

_____

_____

_____

Signature of Patient (or parent if patient is a minor)