Lancaster SMILES
Family & Cosmetic Dentistry

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MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: ( ) _____

Do you have or have you ever had any of the following?
Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Diabetes	[ ] Heart Surgery*	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV*/AIDS	[ ] Sinus Problems
[ ] Artificial Joints*	[ ] Fever Blisters/Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves*	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder (Congenital)*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection*	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur*	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker*	[ ] Respiratory Problems	[ ] Yellow Jaundice

*This condition may require antibiotic premedication for certain dental procedures.

Yes **No**

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, please explain: _____

[ ] [ ] Are you now under the care of a physician?
If yes, please explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, please list: _____

[ ] [ ] Are you allergic to any medications or substances? Please check appropriate boxes below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Metal [ ] Latex [ ] Sulfa [ ] Other: _____

[ ] [ ] Have you used tobacco? How many years? _____
[ ] Cigarettes [ ] Chewing Tobacco [ ] Cigars [ ] Pipe

WOMEN (Please check any that apply)
[ ] Pregnant [ ] Nursing [ ] Birth Control

To the best of my knowledge, all of the preceding information is correct. If I have any changes in my health status or medications, I will inform the dentist and staff at the next appointment without fail.

X_____ Date: ____/____/_____