LANCASTER SMILES

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Medical History Update

Your Health Matters

At Lancaster Smiles Dental Studio, we believe excellent dentistry begins with understanding your overall health. Many medical conditions, medications, and lifestyle changes directly affect your oral health, healing, comfort, and long-term treatment outcomes. This information allows us to provide care that is safe, personalized, and appropriate for your individual needs. Please let us know if you have any questions or concerns about your health or dental care.

Please review the following information carefully

Since your last visit, have you had any changes in your health?

☐ No changes ☐ Yes (please explain): _____

Have you experienced any of the following since your last visit?

☐ Change in physicians ☐ Change in medications ☐ Emergency room visit ☐ Hospitalization ☐ New allergies
☐ New medical diagnosis ☐ Pregnancy ☐ Surgery ☐ Significant weight change ☐ Other
Please explain:

Medications

Have you started or stopped any prescription medications, over-the-counter medications, vitamins, or supplements?

☐ No ☐ Yes Please list:_____

Allergies

Have you developed any new allergies or reactions to medications, latex, or other substances?

☐ No ☐ Yes Please explain:_____

Tobacco, Nicotine, Alcohol & Recreational Drug Use

Has your use changed?

☐ No ☐ Yes Please explain:_____

Oral Health & General Health

Have you noticed any of the following?

☐ Bleeding gums ☐ Facial swelling ☐ Sleep concerns or snoring ☐ None
☐ Difficulty chewing ☐ Jaw pain or clicking ☐ Sores that have not healed Additional comments: _____
☐ Dry mouth ☐ Loose teeth ☐ Tooth sensitivity _____

Your Dental Goals

Has anything changed regarding your goals for your smile or oral health?

☐ I want to keep my teeth healthy for life. ☐ I want to replace missing teeth.
☐ I want to improve function or chewing. ☐ I want to improve the appearance of my smile.
☐ I am interested in implants. ☐ I am interested in Invisalign.
☐ I am interested in cosmetic dentistry. ☐ No changes.
Comments:

Have you tested positive for or been diagnosed with any of the following in the last 2 weeks?

☐ COVID-19 ☐ Measles ☐ RSV ☐ None
☐ Influenza (flu) ☐ Pneumonia ☐ Strep throat ☐ Other contagious infection: _____

In the last 7 days have you experienced any of the following?

☐ Fever or chills ☐ Cough ☐ Sore throat ☐ Runny or stuffy nose/congestion ☐ Shortness of breath/difficulty breathing
☐ Unusual fatigue or body aches ☐ Headache associated with a respiratory illness ☐ Loss or change of taste or smell
☐ Pink/red or watery eyes (conjunctivitis) ☐ Rash or unexplained skin eruption ☐ None of the above

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MEASLES SCREENING

In the past 21 days, have you:

☐ Been exposed to someone with confirmed or suspected measles?
☐ Been notified by the Pennsylvania Department of Health or another health department of a possible measles exposure?
☐ Been exposed to someone with COVID-19, influenza, RSV, or another contagious respiratory infection?
☐ Lived with or had close contact with someone who is currently sick with a contagious respiratory illness?
☐ None of the above

Have you received 2 documented doses of MMR (measles, mumps, rubella) vaccine, or otherwise been told by your healthcare provider that you are immune to measles?

☐ Yes ☐ No ☐ Unsure

If you answered NO or UNSURE, please discuss your measles immunity with your healthcare provider.

IMPORTANT:
If you currently have a fever, significant respiratory symptoms, suspected or confirmed COVID-19, influenza, RSV, measles, or another contagious illness**, please contact our office before coming to your appointment.**

If you have had a possible measles exposure or symptoms suggestive of measles (fever, cough, runny nose, red/watery eyes, followed by a rash), **please do not enter the dental office without speaking with us first.**

Your appointment may need to be postponed, or special arrangements made to protect you, our patients, and our team.

Patient Certification

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that changes in my medical history may affect my dental treatment and that it is my responsibility to inform the office of any future changes.

Patient Name: _____

Signature: _____

Date: _____