LAURELWOOD FAMILY DENTISTRY

Health Information

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the entire form.

NAME: _____ Birth Date: _____/ _____/ _____
Day Month Year

Name of Family Physician (MD)_____

If a NEW patient to our office: Date of last Dental Visit _____/_____
Month Year

By whom were you referred? _____.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK.

☐ Chest pain/angina	☐ Shortness of Breath	☐ High blood pressure	☐ Low blood pressure
☐ Heart attack	☐ Lung Disease	☐ Prosthetic heart valve	☐ Women: At the present time are you pregnant. Due date:_____
☐ Stroke	☐ Tuberculosis	☐ Pacemaker	
☐ Asthma	☐ Diabetes	☐ Prosthetic or artificial joint	
☐ Bleeding problems/disorder	☐ Hepatitis	☐ Seizures (epilepsy)	☐ Breast Feeding
☐ Cancer	☐ Arthritis	☐ Jaundice	Other
☐ Steroid therapy	☐ Stomach ulcers	☐ Liver disease	☐ _____
☐ Thyroid disease	☐ Drug dependency	☐ Kidney disease	_____
☐ Rheumatic Fever	☐ Alcohol dependency	☐ Diet Pill Therapy	_____

- Are there any conditions or diseases not listed above that you have or have had? ☐ Maybe ☐ Yes ☐ No
  If yes, please explain:_____
- Are there any diseases or medical problems that run in your family? ☐ Maybe ☐ Yes ☐ No
  If yes, please explain:_____
- Do you smoke or chew tobacco products?_____ ☐ Yes ☐ No
- Are you being treated for any medical condition at the present or have you been treated within the past year? ☐ Yes ☐ No
  If yes, please explain:_____
- Has there been any change in your general health in the past year? ☐ Maybe ☐ Yes ☐ No
  If yes, please explain:_____
- Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Maybe ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any allergies? If yes, please list using the categories below:? ☐ Yes ☐ No
  Medications_____ Latex/Rubber products_____Other e.g. food_____
- Have you ever had a peculiar or adverse reaction to any medications or injections? ☐ Maybe ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? _____ ☐ Yes ☐ No
- Have you ever been advised by your doctor to take antibiotics **BEFORE DENTAL TREATMENT**? _____ ☐ Yes ☐ No
- Do you have any conditions or therapies that could affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)
  _____ ☐ Yes ☐ No
- Have you ever been hopitalized for any illnesses or operations? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all the above answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____/ _____/ _____
Signature of patient, parent or guardian Today's Date: Day Month Year