LANE & ASSOCIATES
Family Dentistry
We love to make you smile!

Patient Medical History Update

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Current Phone Numbers: _____

Email Address: _____

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care. If we determine that questions have not been answered honestly you will be dismissed from our practice.

Please Circle the Correct Response

Are you allergic to, or have you had unusual reactions to any of the following? Circle all that apply: Penicillin Aspirin Iodine Codeine Sulfa Drugs
Barbiturates Erythromycin Latex Other: _____

Have you ever been seriously ill? Yes No
Have there been any changes in your general health recently? Yes No
Are you currently being treated by a medical Doctor?
If yes, what is the Doctors Name? _____
Phone Number? _____
Are you currently taking any medications? Yes No
If yes please list _____
Have you ever been hospitalized? Yes No
When? _____
Have you ever had a major operation? Yes No
Have you had a physical exam in the last year? Yes No
Have you ever had to take antibiotics before having dental work? Yes No
Do you have artificial joints or heart valves? Yes No
Do you have chest pains upon exertion? Yes No
Have you ever had x-rays for a tumor, growth or any other condition? Yes No
Have you ever been exposed to the AIDS virus (HIV)? Yes No
Would you consent to a blood test (at our expense) if the Doctor or staff member suffers a needle stick or puncture wound? Yes No
Are you currently using any recreational drugs such as cocaine? Yes No
Have you ever had a blood transfusion? Yes No
Have you ever experienced an unusual reaction to dental anesthetic? Yes No
Have you ever been told that any of the following pertain to you?

Mitral Valve Prolapse	Yes	No	Heart Murmur	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Heart Attack	Yes	No	Herpes	Yes	No
Hives/Skin Rash	Yes	No	Epilepsy	Yes	No
Seizures	Yes	No	Anemia	Yes	No
AIDS	Yes	No	Rheumatic Fever	Yes	No
Hepatitis	Yes	No	Tuberculosis	Yes	No
Stroke	Yes	No	Jaundice	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No

Venereal Disease	Yes	No	Kidney Disease	Yes	No
Arthritis	Yes	No	Other: _____		

Do you bleed for a long time when you cut yourself?	Yes	No
Do you have frequent or severe headaches?	Yes	No
Do you have sinus trouble?	Yes	No
Do you have painful or swollen joints?	Yes	No
Do you have frequent cold sores or canker sores?	Yes	No
Do you have complaints about your ears/hearing?	Yes	No
Do you have frequent colds?	Yes	No
Are you nervous?	Yes	No
Have you lost or gained weight in the last few months?	Yes	No
Has your appetite changed recently?	Yes	No
Are there any foods that you cannot eat?	Yes	No

For Women Only

Are you pregnant?	Yes	No
Are you taking oral contraceptives (birth control pills)?	Yes	No

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics. Antibiotics can cause failure of birth control pills which could result in pregnancy.

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature: _____ Date _____