LAKEWAY COSMETIC DENTISTRY & IMPLANT SURGERY

MEDICAL HEALTH

NAME: _____ DOB: _____ DATE: _____

CHECK ALL THAT APPLY

_____ Abnormal Blood Pressure
_____ AIDS
_____ Anemia
_____ Asthma
_____ Congenital Heart Disease
_____ Epilepsy/Seizures
_____ Fainting Spells
_____ Heart Disease
_____ Heart Murmur/Mitral Valve Prolapse
_____ Immunosuppressed Disorder
_____ Prolonged Bleeding Disorder
_____ Rheumatic Fever
_____ Sinus Trouble
_____ Stroke
_____ Tuberculosis or Lung Disease
_____ Ulcers
_____ Arthritis
_____ Cancer/Chemotherapy
_____ Diabetes
_____ Hearing Loss
_____ Hepatitis Type: _____
_____ Herpes
_____ History of Drug Addiction
_____ Infectious Mononucleosis (Mono)
_____ Kidney Disease
_____ Liver Disease
_____ Radiation Treatment
_____ Sexually Transmitted Disease
_____ Tumor or Malignancy
_____ History of Emotional or Nervous Disorder
_____ I saw this column of Medical Information

_____ Implants/Artificial Joints: ☐ Teeth ☐ Hip ☐ Knee ☐ Other: _____
_____ I smoke or use tobacco. If yes, how many per day? _____ How many years? _____
_____ I have consumed alcohol within the last 24 hours
_____ I usually take an antibiotic prior to dental treatment
_____ I have had major surgery: Year: _____ Type of Operation: _____
_____ Any other major medical condition not listed? _____

Allergies:

_____ **None**
_____ Aspirin
_____ Vicodin
_____ Sulfa Drugs
_____ Amoxicillin
_____ Penicillin
_____ Codeine
_____ Latex, Metals, Plastics
_____ Local Anesthetics (Novocain, etc)

Other: _____

Current Medications

List any medications you are currently taking:

_____ **None**

Medication: _____
Reason: _____

Medication: _____
Reason: _____

Medication: _____
Reason: _____

WOMEN ONLY

Are you taking birth control medication?	Y	N
Are you or could you be pregnant?	Y	N
Are you nursing?	Y	N