MEDICAL HISTORY

Lancaster Dental Associates

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name: _____ Sex: O Male O Female

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Ext:_____

Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

Are you under a physician's care now?	Yes	No	If yes:_____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes:_____
Have you ever had a serious head or neck injury?	Yes	No	If yes:_____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please list:
Does your Doctor require Premedication prior to a dental appointment?	Yes	No	_____ _____ _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____ _____
Have you ever taken Fosamax, Boniva, Actone, or any other medication containing bisphosphonates?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you

Currently Pregnant?	Yes	No	If yes:_____
Taking Oral Contraceptives?	Yes	No	
Nursing?	Yes	No	

Are you allergic to any of the following? (circle) Aspirin Acrylic Penicillin

Metal Codeine Latex Local Anesthetics Sulfa Drugs

Other:_____

Do you have, or have you had any of the following:

AIDS/HIV Positive	Y N	Alzheimer's disease	Y N	Anaphylaxis	Y N	Angina	Y N
Artificial Heart Valve	Y N	Artificial Joint	Y N	Asthma	Y N	Blood Disease	Y N
Blood Transfusion	Y N	Bruise Easily	Y N	Cancer	Y N	Chemotherapy	Y N
Chest Pains	Y N	Cold Sores/Fever Blisters	Y N	Congenital Heart Disorder	Y N	Convulsions	Y N
Cortisone Medicine	Y N	Diabetes	Y N	Drug Addiction	Y N	Easily Winded	Y N
Emphysema	Y N	Epilepsy/Seizures	Y N	Excessive Bleeding	Y N	Excessive Thirst	Y N
Fainting/Dizziness	Y N	Frequent Cough	Y N	Frequent Headaches	Y N	Glaucoma	Y N
Heart Attack/Failure	Y N	Heart Murmur	Y N	Heart Pacemaker	Y N	Heart Trouble/Disease	Y N
Hemophilia	Y N	Hepatitis A	Y N	Hepatitis B or C	Y N	High Blood Pressure	Y N
Hives/Rash	Y N	Hypoglycemia	Y N	Irregular Heartbeat	Y N	Kidney Problems	Y N
Leukemia	Y N	Liver Disease	Y N	Low Blood Pressure	Y N	Lung Disease	Y N
Mitral Valve Prolapse	Y N	Osteoporosis	Y N	Jaw Joint Pain	Y N	Parathyroid Disease	Y N
Psychiatric Care	Y N	Radiation Treatments	Y N	Renal Dialysis	Y N	Rheumatism	Y N
Shingles	Y N	Sickle Cell Disease	Y N	Sinus Trouble	Y N	Stomach/Intestinal Disease	Y N
Stroke	Y N	Swelling of Limbs	Y N	Thyroid Disease	Y N	Tonsillitis	Y N
Tuberculosis	Y N	Tumors/Growths	Y N	Ulcers	Y N		

Comments: _____

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_____

Primary Physician:_____

Physician Phone Number:_____

Signature: _____