# LAKEAVENUEDENTAL

## • Medical History •

**Patient's Name**_____________________________**DOB**_________**Today's Date**________________________

**Medical Physician's Name**________________________________________________________________________

**Pharmacy Name and Location**_________________________________________________________________

**List ALL Medications you currently taking** (including supplements and over-the-counter meds):_________________________________________________________________________________________
_________________________________________________________________________________________

**Blood Thinners**: ( )Aspirin ( )Plavix ( )Coumadin ( )Pradaxa ( )Eliquis ( )Xarelto ( )Other___________

**Prosthetic Heart Valve or Joint Replacement** (i.e. Hip, Knee, Ankle, etc)? ( )Yes ( )No Date:___________

**Have you ever been told that you need to take antibiotics prior to dental appointments?** ( )Yes ( ) No

**Allergies:** ( )Latex ( )Penicillin ( )Tetracycline ( )Aspirin ( )Metals ( )Other_________________________

**Have you ever taken bone-loss prevention drugs such as:** ( )Zometa ( )Boniva ( )Fosamax ( )Actonel

( )Prolia ( )Other chemotherapy bone medications ________________________________________________

**Please check if you have had any of the following:**

| | | | |
|---|---|---|---|
| ( ) Anemia | ( ) Abnormal Bleeding | ( ) Herpes | ( ) HPV |
| ( ) Diabetes | ( ) Difficulty Breathing | ( ) HIV + AIDS | ( ) Kidney Problems |
| ( ) Angina | ( ) Drug/Alcohol Abuse | ( ) Heart Attack | ( ) Liver Disease |
| ( ) Arthritis | ( ) Heart Disease/Surgery | ( ) Emphysema | ( ) Pacemaker |
| ( ) Asthma | ( ) Fainting/Dizzy | ( ) Seizures | ( ) Headache/Migraine |
| ( ) Autoimmune | ( ) Fever Blisters | ( ) Hep A, B, or C | ( ) Sinus Issues |
| ( ) COPD | ( ) Sleep Apnea | ( ) Stroke | ( ) Low Blood Pressure |
| ( ) Cancer/Radiation | ( ) High Blood Pressure | ( ) GI or Reflux | ( ) Thyroid Disease |

**Other Medical Conditions not mentioned above:**_______________________________________________

**Women Only:** ( ) Birth Control Medication ( ) Pregnant: # Weeks ________Are you Nursing? ( )Y ( ) N

Notes:_________________________________________________________________________________
_______________________________________________________________________________________

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I understand the information I have given today is correct to the best of my knowledge.  I also understands that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

**Patient (or parent/guardian) Signature ________________________________ Date ________________**