

**LaFevers Dental Team- Medical History**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Dental Insurance Co: \_\_\_\_\_

Do you require **Pre-Medication** (Antibiotic) prior to dental appointments? YES NO

Do you have any **artificial joints**? (Hip/Knee Replacement? Etc) YES NO

Are you currently on a **blood thinner**? YES NO

Do you have **High Blood Pressure**? YES NO

Please list all **allergies** (Latex? Penicillin? Codeine? Red Dye? Etc): \_\_\_\_\_

*Check all that apply:*

- AIDS/HIV
- Autism/Spectrum Disorders
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
  - o Type? \_\_\_\_\_
  - o Remission? Yes No
- Diabetes
- Dizziness/Fainting
- Epilepsy
- Excessive Bleeding
- Growths
- Hay Fever
- Head Injury
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Heart Attack
  - o When? \_\_\_\_\_

- High Cholesterol
- Organ Transplant
- Dialysis
- Kidney Disease
- Liver Disease
- Pacemaker
- Radiation
  - o What Type \_\_\_\_\_
- Rheumatic Fever
- Respiratory Problems
- Reaction to anesthetic
- Stomach Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Thyroid Problems
- Heart Disease
- Pregnant
  - o Due Date: \_\_\_\_\_
- Breastfeeding
- Surgery
  - o Type? \_\_\_\_\_

Have you ever taken? (Circle) Actonel Boniva Fosamax Reclast Prolia Alendronate

Please list all **Medications/Dosages/Reason** for taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

*To the best of my knowledge, all the preceding 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.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_