Medical History

Patient Name: _____ Date of Birth: _____

Are you under the care of a physician now? _____

If so, for what condition? _____

Physician's name: _____ Clinic: _____ Phone #: _____
My last physical examination was: Date: _____ Result: _____

What surgeries have you had? _____

Are you taking any medications or pills of any kind, prescription or non-prescription? _____
If yes, list name and condition:

_____ _____
_____ _____
_____ _____

Nutritional supplements? _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY ILL EFFECTS FROM ANY LOCAL ANESTHETIC OR OTHER DRUG, OR MEDICINE? _____

Allergies to: Tetracycline/ Penicillin/ Sedatives/ Aspirin/ Latex/ Metal
Other _____

HAS YOUR PHYSICIAN RECOMMENED ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL VISITS? _____

If so, what for _____

Have you ever had cardiac trouble/ heart attack/ stroke/ TIA/ pacemaker or defibrillator?
Date: _____
Have you had heart surgery/ angioplasty/ heart valve replacement/ stents?
If so, date: _____

Chest pains upon exertion? Do you get short of breath easily?_____

Has your blood pressure been checked in the last year? _____ Results? _____

Have you taken steroid therapy or cortisone in the past year? _____

Do you bruise easily/take any blood thinners? _____

Have you had abnormal bleeding from a cut or tooth extraction? _____

Have you had bisphosphonate therapy (i.e. Fosamax/zometa) in the past 15 years? _____

Do you use tobacco? _____

FEMALE: Are you taking oral contraceptives? _____
Are you nursing? _____ Do you think you are pregnant or are you pregnant at this time? _____
Approximate due date: _____

HAVE YOU EVER HAD? (Please mark yes or no)

Yes	No		Yes	No	
___	___	Hepatitis or Jaundice/ Type___	___	___	Rheumatic Fever
___	___	Immune Suppressed/Auto-Immune condition	___	___	Anemia
___	___	Total hip or knee joint replacement Date:_____	___	___	Blood diseases/disorders/Leukemia
			___	___	Circulatory problems
___	___	Blood Pressure: HIGH	___	___	Asthma
___	___	Blood Pressure: LOW	___	___	Tuberculosis
___	___	History of heart murmur	___	___	Bronchitis/Emphysema
___	___	Thyroid Problem	___	___	Glaucoma/cataracts/blindness
___	___	Kidney or Liver involvement	___	___	Chronic sinus
___	___	Epilepsy/seizures/convulsions	___	___	Venereal disease/Herpes II/HPV
___	___	Fainting spells/dizziness	___	___	Sleep apnea
___	___	Chronic headaches/migraines	___	___	Back problems
___	___	Psychiatric care/ emotional concerns	___	___	Hives/ skin rash
___	___	Autism/Asperger's Syndrome	___	___	Aneurysm
___	___	Diabetes Type I or II	___	___	Atrial fibrillation (with Coumadin)
___	___	Radiation therapy/ Chemotherapy	___	___	Osteoporosis/ Osteopenia
___	___	Any form of tumor/ malignancy Date: _____ Description: _____	___	___	Hearing problems
			___	___	Arthritis
			___	___	Xerostomia (dry mouth)
___	___	TMJ/jaw joint disorder	___	___	Heartburn/ gastric reflux/ ulcers
___	___	Bulimia/ anorexia/ other eating disorder			
___	___	Substance abuse: alcoholism/ drug addiction			

Is there anything else I should know about your health history or you would like to speak with Dr. Lesch about in private? _____
_____

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Date: _____ Signature: _____

UPDATE

Initials Date Comments or Changes

_____
_____
_____
_____
_____
_____
_____

Dr. James F. Lesch _____ ASA I II III

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