

MEDICAL HISTORY

Your health information is essential to our ability to efficiently and effectively treat your dental requirements. Please complete this information accurately. All personal information is strictly confidential and used exclusively by, By the Lake Dental. **PLEASE PRINT CLEARLY.**

Patient Name: _____

Family Doctor: _____ **Phone Number:** _____

Are you being treated for any medical conditions at the present time? **Yes** **No** **Details:** _____

Please check if you have had or have any of the following conditions:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergies (Please list): _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Pregnant (months) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | Prosthetic: <input type="checkbox"/> limb <input type="checkbox"/> organ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> HIV related issues | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Kidney issues | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bleeding | | | <input type="checkbox"/> Stomach issues |
| <input type="checkbox"/> Cancer (Please list): _____ | | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver issues | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart valve surgery | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Smoker | How Long? _____ | Frequency of use: _____ | |
| <input type="checkbox"/> Cannabis | How Long? _____ | <input type="checkbox"/> Medicinal <input type="checkbox"/> Recreational | Frequency of use: _____ |
- Other conditions: _____

Please list any current medication, including over the counter (if you need additional space, please write on the back of this page)

DENTAL HISTORY

My most recent dental visit: _____ I see my dentist every: 3 months / 6 months / 12 months / Not routinely

Have you ever had local anesthetic? (Freezing) Yes / No were there any complications? Yes/ No

Have you ever had Botox treatment before? Yes / No If yes, what was the reason? *Cosmetic / Therapeutic*

Please circle if any of the following apply to you:

Bleeding Gums	Unpleasant Taste/ Bad Breath	Frequent Blisters	Swelling/ Lumps in mouth	Ortho Treatment
Difficulty Chewing	Teeth Sensitivity Hot/ Cold	Clicking/ Popping jaw	Clenching Grinding/TMJ	Headaches

I understand the above information is necessary to provide me with dental care in a safe, efficient and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my consent to ask the respective health care provider to release such information. I will notify the dentist of any change to my health or medication.

Print Name

Relationship to
Patient

Signature

Date