**LAKE FAMILY DENTAL: HEALTH HISTORY**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently under the care of a physician for a specific condition? YES \_\_\_\_NO\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use tobacco in any form? YES\_\_\_NO\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marijuana /cannabis use? \_\_\_\_\_­­­­­­­­­­­­­­­­­­­** **Method of delivery?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Women ONLY: Are you taking birth control? YES\_\_\_NO\_\_\_ Are you pregnant? YES\_\_\_NO\_\_\_**

**Are you Nursing? YES\_\_\_NO\_\_\_**

**Are you allergic to any of the following?**

**Y N Aspirin Y N Erythromycin Y N Sulfa**

**Y N Codeine Y N Latex Y N Tetracycline**

**Y N Dental Anesthetics Y N Penicillin Y N Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What prescription/over the counter drugs are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any of the following diseases or medical problems?**

**Y N Abnormal Bleeding Y N Hepatitis \_\_\_\_\_\_\_Type**

**Y N Alcohol/Drug Abuse Y N Herpes/Fever Blisters**

**Y N Anemia Y N High Blood Pressure**

**Y N Arthritis Y N HIV+/Aids**

**Y N Artificial Joints/Heart Valves Y N Hospitalized for any reason (list below)**

**Y N Asthma Y N Kidney Problems**

**Y N Blood Transfusion Y N Liver Problems**

**Y N Cancer/Chemotherapy Y N Low Blood Pressure**

**Y N Colitis Y N Mitral Valve Prolapse**

**Y N Congenital Heart Defect Y N Pacemaker**

**Y N Diabetes Y N Psychiatric Problems**

**Y N Difficulty Breathing Y N Radiation Treatment**

**Y N Emphysema Y N Rheumatic/Scarlet Fever**

**Y N Epilepsy Y N Seizures**

**Y N Fainting Spells Y N Shingles**

**Y N Frequent Headaches Y N Sickle Cell Disease**

**Y N Glaucoma Y N Sinus Problems**

**Y N Hay Fever Y N Stroke**

**Y N Heart Attack Y N Thyroid Problems**

**Y N Heart Murmur Y N Tuberculosis (TB)**

**Y N Heart Surgery Y N Ulcers**

**Y N Hemophilia Y N Venereal Disease**

**Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize the taking of diagnostic x-rays and photographs, if necessary while a patient of Dr. Matthew Lake for purposes of diagnosis, treatment and consultation with other medical or dental colleagues.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date Signature Date**