**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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**