

Health History Form
Timothy M. Lawrence, DDS, MS, Inc.

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Name _____ Today's Date _____

Male Female Date of Birth _____

Height _____ Weight _____

Medical History

Are you in good health? Yes No

If No, please explain:

Have there been any changes in your health in the past 12 mos.? Yes No

If Yes, please explain:

Are you now under the care of a physician? Yes No

If Yes, please explain:

The name and address of my physician is:

Please list the date of your last physical examination by your physician. _____

Have you had any serious illness, significant operation or hospitalization within the past 5 years? Yes No

If so, please explain:

Do you take any blood thinning medications? Yes No

If so, please list here:

Do you take any medications? (this includes all non-prescription, homeopathic or "natural" remedies including diet pills) Yes No

If so, please list ALL MEDICATIONS here:

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Select any of the following if you presently have or have had the condition in the past:

Medical Alerts:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy to Penicillin | <input type="checkbox"/> Allergy to Local Anesthetics | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Allergy to Codeine | <input type="checkbox"/> Automatic Defibrillator |
| <input type="checkbox"/> Allergy to Aspirin | <input type="checkbox"/> Allergy to Other Medication | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Allergy to Motrin(ibuprofen) | <input type="checkbox"/> Reaction to General Anesthesia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergy to Sulfa Drugs | <input type="checkbox"/> Heart Valve Deformity or Surgery | <input type="checkbox"/> Joint Replacement |

Please Describe Reactions or Details of the Above or Other Allergies Here:

Medical Conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> GI Upset |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Chest Pain (angina) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> TB (tuberculosis) |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Coronary Artery Stent | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> CHF (congestive heart failure) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Deep Vein Clot | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Frequent Cough |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Excessive Bleeding when Cut | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Extreme Nervousness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hives | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cortisone/predisone Treatment | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Recreational Drug Use (cocaine, etc.) |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Other |

Please Explain Any of the Above Here:

Do you smoke?

Yes No

If so, # of packs per day, _____ for _____ years.

Do you want to talk to the doctor privately about anything?

Yes No

Do you wear contact lenses?

Yes No

Family History:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Reactions to General Anesthesia | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Other |

Please Explain Any of the Above Here:

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Women

Are you pregnant or are you trying to become pregnant? Yes No
Do you have problems associated with your menstrual period? Yes No
Are you nursing? Yes No

Dental/Oral Surgery History

For what are you seeing Dr. Lawrence? _____

What type of anesthesia would you prefer or like more information regarding?

- Asleep(general/deepsedation)
- Sedated (IV or oral)
- Numb
- Numb with Nitrous Oxide (laughing gas)

Indicate anesthesia related comments or questions here: _____

Please explain any unpleasant past dental/oral surgical experience. _____

Have you seen any other doctor/dentist for this problem? Yes No

If so, please explain:

Do you have TMJ (jaw joint problems)? Yes No

If so, please explain:

Are you wearing or do you use any removable dental appliance or prosthesis? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction

Date _____ Signature of Patient or Guardian _____

For Completion by the Doctor:

Comments on patient interview concerning medical or dental history:

ASA Classification: I II III

Date _____ Drs. Signature _____

Medical History Updates:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____