Dr. Kevin Lathangue
Dr. Jana Lamb
Dr. Joseph Schafermeyer
Dr. Justin Patterson

Confidential Medical History

Patient's Name:_________________________________ Date of Birth: ______________________

Tel (H): _________________________ Cell: ____________________ Work: ____________________

Email: _________________________________

1. Has there been any change in your health in the last year? Yes No
2. Name of Medical doctor: _______________________________________
3. When was your last medical examination? ________________________
4. Are you currently being treated by a Physician? Yes No
   If Yes, why? ________________________________________________
5. Have you been hospitalized or had a serious accident in the last 5 years? Yes No
   If Yes, Why? ________________________________________________
6. Please circle Yes or No for the following conditions, have you ever had:

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | Y | N | Hepatitis/Jaundice/Liver | Y | N |
| Diabetes | Y | N | Arthritis/Rheumatism | Y | N |
| Stomach Ulcers | Y | N | Anemia | Y | N |
| Artificial Joint | Y | N | Artificial Heart Valve | Y | N |
| Epilepsy/Seizures | Y | N | Rheumatic Fever | Y | N |
| Thyroid Disease | Y | N | Frequent Severe Headaches | Y | N |
| Cancer/Tumor | Y | N | High/Low Blood Pressure | Y | N |
| Tuberculosis | Y | N | Venereal Disease/AIDS | Y | N |
| Sinus Trouble | Y | N | Kidney Disease | Y | N |
| Drug/Alcohol Addiction | Y | N | Mental/Nervous Disorder | Y | N |
| Fainting Spells | Y | N | Heart Murmur | Y | N |
| Scarlet Fever | Y | N | Alzheimer's | Y | N |

7. Please circle any medications you are now taking:

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics | Y | N | Anticoagulants | Y | N |
| Tranquilizers | Y | N | Cortisone/Steroids | Y | N |
| Aspirin | Y | N | Antihistamines | Y | N |
| Heart Drugs | Y | N | Insulin | Y | N |
| Blood Pressure Medicine | Y | N | Nitroglycerin | Y | N |
| Other: _____________________ | | | | | |
| FOR WOMEN ONLY: | | | | | |
| Hormonal Therapy | Y | N | Oral Contraceptives | Y | N |
| | | | | | |

8. Do you have any instructions from a Physician to take pre-medication for dental work? Yes No If Yes, what? _______________________________________________

9. Are you allergic to or have you ever experienced an unusual reaction to:

| | | | | | |
|---|---|---|---|---|---|
| Latex | Y N | Fluoride | Y N | Metals | Y N |
| Jewelry | Y N | Nitrous Oxide | Y N | | |
| Dental Anesthesia (local) | Y N | | | General Anesthesia | Y N |

10. Are you allergic to or have you ever had any reaction to any of the following drugs?

| | | | |
|---|---|---|---|
| Penicillin (or related drugs) | Y N | Clindamycin | Y N |
| Aspirin/Ibuprofen (Advil, Motrin) | Y N | Tetra Cycline | Y N |
| NSAID (Celebrec, Vioxx, Anaprox) | Y N | Sulfa drugs | Y N |
| Tranquilizers (Valium) | Y N | Erythromycin | Y N |
| Keflex (Cephalexin) | Y N | Codeine | Y N |

11. Do you bleed excessively when cut? Y N
12. Have you had any injuries to the face and jaws? Y N
13. Do you smoke? Y N
14. (WOMEN) Are you pregnant? Y N
    Expected due date? _______________________

15. Have you ever been diagnosed with sleep apnea or do you use a c-pap machine? Y N

16. What brings you in today?
    ________________________________________________________________________
    ________________________________________________________________________

17. Is there anything regarding your health that we have not discussed that would be important for us to know before we begin?
    ________________________________________________________________________
    ________________________________________________________________________

18. Why did you leave your last dental office?
    ________________________________________________________________________
    ________________________________________________________________________

Emergency Contact _______________________ Phone:______________ Relationship: ______________

CONSENT – to the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider (s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health and dental care>

Clients Signature: __________________________________ Date: _______________________

Reviewed by: _____________________________________ Date: ________________________

MEDICAL UPDATES:

Date: ______________________________ Comments: ________________________