Lindenhurst Dental Health Group *1909 E. Grand Ave.* *Lindenhurst, IL 60046*

Medical History

Patient Acct No Medical Alert

1 Have you been under the care of a medical doctor for any condition during the past 2 years? Yes No
If yes, for what?_____
Physician's Name_____ Phone_____
Address_____ City_____ State_____ Zip_____
2 Have you taken any medication or drugs during the past two years?..... Yes No
3 Are you takingt any medication,drugs or pills now?..... Yes No
If yes,please list name and dosage_____
4 **Are you aware of having an allergic(or adverse reaction) to any medication or substance?.....** Yes No

If so,Please list _____
5 Have you been a patient in the hospital during the past five years?..... Yes No
6 Indicate which of the following you have had,or have at present.Circle "yes" or "no" to each item.

Heart(**Surgery?Disease?Attack?**)	Yes	No	Ulcers	Yes	No	HepatitisA(Infectious) B(serum)	Yes	No
Heart Surgery **Type**_____			Diabetes	Yes	No	Venereal Disease	Yes	No
Heart Disease **Type**_____			Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V.Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	**Hemophilia**	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	**Latex Sensitivity**	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies/Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet(Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting/Dizzy Spells	Yes	No
Artificial Joints(hip,knee,etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric Condition	Yes	No
Month/Year of placement_____			Tumors	Yes	No	Psychological Condition	Yes	No
			Cancer	Yes	No	HPV-Human Papilloma Virus	*Yes*	*No*

7 Do you use more than two pillows to sleep?..... Yes No
8 Have you lost or gained more than 10 pounds in the last year?..... Yes No
9 Do you have or have you had any disease,condition,or problem not listed?..... Yes No
If yes,please list:.....
10 Do you now or have you ever smoked? _____ per day If you quit provide date_____
11 **Women**. Are you: Pregnant? Yes,_____Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

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

Patient/Guardian Signature_____ **Date**_____

History Review

Dentist Signature_____ Date_____