LONE PEAK **DENTAL**
M. SEAN LORSCHEIDER DMD

PATIENT'S NAME _____

Welcome to Lone Peak Dental! Please take a moment to fill out this form as complete as you are able. If you have any questions we would be happy to assist you. We look forward to working with you in maintaining your oral health.

MEDICAL INFORMATION

Y N 1. Are you having any pain or discomfort at this time?

Y N 2. Do you have or have you ever had bleeding or sensitive gums?

Y N 3. Do you feel nervous about having dental treatment?

Y N 4. Have you been hospitalized during the past two years?

Y N 5. Have you been under the care of a medical doctor during the past two years? If YES, please fill in the section below.

PHYSICIAN'S NAME: _____ ADDRESS: _____

TYPE OF PRACTICE: _____ PHONE #: _____

Y N 6. Have you taken any medication or drugs during the past two years?

Y N 7. Are you currently taking any type of medication, pills, or drugs? If YES, please list below.

_____

Y N 8. Are you allergic to or have you reacted adversely to any of the following:

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ NITROUS OXIDE
- ☐ TETRACYCLINE
- ☐ ERYTHROMYCIN
- ☐ PENICILLIN
- ☐ OTHER ANTIBIOTICS
- ☐ LOCAL ANESTHETICS
- ☐ SULFA DRUGS
- ☐ LATEX
- ☐ IBUPROFEN
- ☐ ACETAMINOPHEN
- ☐ BARBITUATES
- ☐ DO YOU HAVE ANY OTHER ALLERGIES? IF SO, PLEASE LIST BELOW:

_____

_____

9. Check any of the following which YOU HAVE HAD or CURRENTLY HAVE:

- ☐ HEART FAILURE
- ☐ HEART DISEASE OR ATTACK
- ☐ ANGINA PECTORIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ RHEUMATIC FEVER
- ☐ CONGENITAL HEART LESIONS
- ☐ SCARLET FEVER
- ☐ HEART PACEMAKER
- ☐ HEART SURGERY
- ☐ ARTIFICIAL JOINTS (HIP, KNEE)
- ☐ ANEMIA
- ☐ STROKE
- ☐ KIDNEY TROUBLE
- ☐ ULCERS
- ☐ COSMETIC SURGERY
- ☐ DRUG ADDICTION
- ☐ EMPHYSEMA
- ☐ COUGH
- ☐ TUBERCULOSIS (TB)
- ☐ ASTHMA
- ☐ HAY FEVER
- ☐ SINUS TROUBLE
- ☐ ALLERGIES OR HIVES
- ☐ DIABETES
- ☐ THYROID
- ☐ X-RAY OR COBALT TREATMENT
- ☐ CHEMOTHERAPY (CANCER,LEUKEMIA)
- ☐ ARTHRITIS
- ☐ RHEUMATISM
- ☐ CORTISONE MEDICINE
- ☐ GLAUCOMA
- ☐ PAIN IN JAW JOINTS
- ☐ COLD SORES
- ☐ AIDS OR HIV
- ☐ HEPATITIS A (INFECTIOUS)
- ☐ HEPATITIS B (SERUM)
- ☐ HEPATITIS C
- ☐ LIVER DISEASE
- ☐ YELLOW JAUNDICE
- ☐ BLOOD TRANSFUSION
- ☐ HEMOPHILIA
- ☐ FEVER BLISTERS
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING OR DIZZY SPELLS
- ☐ NERVOUSNESS OR ANXIETY
- ☐ PSYCHIATRIC TREATMENT
- ☐ SICKLE CELL DISEASE
- ☐ BRUISE EASILY
- ☐ VENEREAL DISEASE
- ☐ OTHER_____

Y N 10. When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you are very tired?

PLEASE CONTINUE ON BACK ▶

MEDICAL INFORMATION - CONTINUED

Y N 11. Do your ankles swell during the day?

Y N 12. Do you use more than 2 pillows to sleep?

Y N 13. Are you on a special diet? If so, please explain _____

Y N 14. Have you ever taken Phen-Fen or a similar suppressant? If YES, have you seen your physician or cardiologist for a cardiac evaluation? Y N

Y N 15. Do you have any disease, condition, or problem not listed? If YES, please explain _____

_____

Y N 16. Have you visited a dentist in the last year? Date of last dental visit _____

Y N 17. FOR WOMEN ONLY - Are you pregnant? If yes, what month? _____

Y N 18. FOR WOMEN ONLY - Are you currently taking birth control pills?

I hereby certify that the above questions have been answered to the best of my knowledge.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN	RELATIONSHIP TO PATIENT	DATE