Lake Country Family Dental
N50 W34770 Wisconsin Avenue • Okauchee, WI 53069 • 262-567-0770

Patient Name: _____ Phone: _____

Medical Information
Answers to the following questions are for our records only and will be considered confidential.

General Health

	yes/no
Are you now under the care of a physician on a regular basis?	☐ ☐
Physician name and phone:	
Are you in good health?	☐ ☐
Date of last physical exam:	
Has there been any change in your general health within the past year?	☐ ☐
If yes, what condition is being treated?	
Have you had a serious illness, operation or been hospitalized in the past five (5) years?	☐ ☐
If yes, what was the illness or problem?	
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐ ☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____ _____ _____	
Women Only Are you pregnant? ☐ ☐ If so, number of weeks?_____ Do you think you might be pregnant? ☐ ☐ Are you nursing? ☐ ☐ Do you take birth control or hormonal replacement? ☐ ☐	

Allergies

Are you allergic to or have you had a reaction to: (for all yes responses, specify type of reaction)	yes/no
Local anesthetics	☐ ☐
Aspirin	☐ ☐
Penicillin and other antibiotics	☐ ☐
Barbiturates, sedatives, or sleeping pills	☐ ☐
Sulfa drugs	☐ ☐
Codeine or other narcotics	☐ ☐
Metals	☐ ☐
Latex (rubber)	☐ ☐
Iodine	☐ ☐
Hay fever/seasonal	☐ ☐
Animals	☐ ☐
Food	☐ ☐
Other allergies	☐ ☐

Current Conditions

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine)?	☐ ☐
Are you taking or scheduled to begin taking any biphosphonates for bone pain, hypercalcemia or skeletal complications resulting from multiple myeloma or metastatic cancer?	☐ ☐
Do you use controlled substances (drugs)?	☐ ☐
Do you use tobacco (smoking, snuff, chew, e-cigs, vaping)?	☐ ☐
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED	☐ ☐
Do you drink soda/sugared/sports drinks?	☐ ☐

Medical History

Do you have or have you ever had any of the following diseases or problems?

yes/no		yes/no	
☐	ADHD	☐	Hepatitis/Jaundice
☐	Anemia	☐	High Blood Pressure
☐	Anxiety	☐	Kidney Disease
☐	Arthritis/Rheumatoid	☐	Leukemia
☐	Asthma	☐	Liver Disease
☐	Autoimmune Disease	☐	Low Blood Pressure
☐	Blood Transfusion	☐	Mentally Challenged
	If yes, date: _____	☐	Migraines/Headaches
☐	Cancer	☐	Mitral Valve Prolapse
☐	Cardiovascular Disease	☐	Neurological Disorders
☐	Chemo/Radiation		If yes, specify:_____
☐	Coumadin	☐	Osteoporosis/Osteopenia
☐	Dementia/Memory Loss	☐	Pacemaker
☐	Diabetes Type I or II	☐	Prostate
☐	Dizziness/fainting	☐	Reflux/Heartburn
☐	Eating Disorder	☐	Respiratory/COPD
☐	Emphysema	☐	Rheumatic Fever
☐	Epilepsy	☐	Sinus Trouble
☐	Gastrointestinal Disease	☐	Sleep Disorder
☐	Glaucoma	☐	STD
☐	Hearing Impaired	☐	Stroke
☐	Heart Attack	☐	Swollen Glands/Neck
☐	Heart Defects	☐	Systemic Lupus
☐	Heart Murmur	☐	Thyroid
☐	Heart Valve Replaced	☐	Tuberculosis
☐	Hemophilia	☐	Ulcers

☐ ☐ **Joint Replacement** Have you had an orthopedic total joint (hip, knee, elbow, finger etc) replacement?
If yes, date: _____
Were there any complications? Please explain.

☐ ☐ **Pre-med** Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If yes, name and phone number of physician or dentist making recommendation.

To the best of my knowledge, I have answered the above questions completely and accurately. Consent: I authorize the doctor to take x-rays, photos and diagnostic aids deemed appropriate to make a thorough diagnosis and to possibly be used for marketing purposes. I authorize the doctor to perform recommended treatment mutually agreed upon and to use the appropriate medication/therapy indicated for such treatment. I understand using anesthetic agents embodies a certain risk. Lastly, I understand it is my responsibility for payment for dental services for myself/dependents due at time of services. A 1-1/2% finance charge (18% APR) may be added to my account.

Patient's Signature: _____ Date: _____

Recall Review

1. Signature:_____ Date: _____
2. Signature:_____ Date: _____
3. Signature:_____ Date: _____
4. Signature:_____ Date: _____