CONFIDENTIAL HEALTH HISTORY

Southpointe Dental
James Lichtsinn, DDS

Patient Name: _____ Date of Birth: _____

Are you being treated by a physician now? If YES, explain_____

Name of physician/Clinic: _____ Date of last medical examination _____

DO YOU SMOKE OR USE TOBACCO PRODUCTS? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Select All That Apply)

❑ Aspirin Allergy ❑ Antibiotics ❑ Codeine Allergy ❑ Latex Allergy

❑ Penicillin Allergy ❑ Local Anesthetic ❑ Novocain ❑ Food: _____

Other Allergies: _____

MEDICAL CONDITIONS - (Select All That Apply)

❑ Arthritis	❑ Acid Reflux	❑ Artificial Joints	❑ Asthma
❑ Artificial Heart Valve	❑ Blood Disorder	❑ Cancer / Tumor	❑ Chemotherapy or Radiation
❑ Chemical Dependency	❑ Cosmetic Surgery	❑ Diabetes	❑ Digestive Problems
❑ Damaged Heart Valve	❑ Eating Disorder	❑ Emphysema	❑ Headaches/Migraines
❑ High Blood Pressure	❑ Heart Attack / Disease	❑ Hepatitis / Liver Disorder	❑ HIV+ / AIDS
❑ Herpes	❑ Hay Fever	❑ Kidney Disease/Trouble	❑ Lung Disease
❑ Low Blood Pressure	❑ Osteoporosis	❑ Persistent Cough	❑ Pregnant or Nursing
❑ Psychiatric Care	❑ Pacemaker	❑ Respiratory Problems	❑ Skin Disease
❑ Stroke	❑ Sinus Trouble	❑ Sleep Apnea/CPAP	❑ STD
❑ Seizures / Epilepsy	❑ Tuberculosis (TB)	❑ Surgery: _____	

❑ Other: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST *THREE* MONTHS? (Please circle)

Antibiotics Aspirin Coumadin Blood Thinners Birth Control: _____

Recreational Drugs Bisphosphonates: Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid

MEDICATIONS AND PRESCRIPTIONS: Please list any supplements, prescriptions or recreational drugs:

_____

_____

Is there any issue or condition that you would like to discuss with the dentist in private? YES NO

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr Lichtsinn of any changes in my health and/or medications.

I authorize the Dr Lichtsinn to contact my physician if needed regarding concerns of my medical information. If Dr Lichtsinn should determine that there may be a potential medically compromised situation, medical consultation may be needed prior to dental treatment. I will not hold my Dr Lichtsinn or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of patient (or guardian if minor) **Date**

Relationship to Patient if Applicable: _____