Professional Lane Dental Associates
MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Date _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

	Yes	No
Acid Reflux		
Alcohol/Chemical Dependency		
Alzheimers		
Anemia		
Arthritis		
Artificial Joints		
Premedication Needed		
Asthma		
Autism		
Blood Disease		
Blood Pressure		
High		
Low		
Blood Thinner/Aspirin		
Cancer		
Chemotherapy		
C-Pap Machine		
Diabetes		
Dizziness		
Eating Disorder		
Epilepsy/Seizures		
Excessive Bleeding		
Fainting		
Glaucoma		
Hay Fever		
Head Injuries		
Heart Disease		
Premedication needed		
Hepatitis		
HIV/AIDS		
Kidney Disease		
Latex Allergy		
Liver Disease		
Lupus		
Mental Disorders		
Mitral Valve Prolapse		
Premedication needed		
Nervous Disorders		
Pacemaker		
Pregnant Now?		
Radiation Treatment		

	Yes	No
Respiratory Problems		
Sinus Problems		
Snoring		
Stomach Problems		
Stroke		
Thyroid		
Tobacco		
Tuberculosis		
Tumors		
Ulcers		
Veneral Disease		

Any other medical condition we need to know about:

_____

_____

_____

_____

Have you ever had an allergic reaction to dental injection/novocaine?

_____

_____

	Yes	No
Allergies to:		
Latex		
Codeine		
Penicillin		
Sulfa		
_____		
_____		
_____		

Current Medication & Dosage

_____

_____

_____

_____

Patient Signature: _____