Dr Lakani Dental Care

Name: _____ Phone: _____ DOB: _____

Medical History

Name of primary care physician: _____

Name of specialist/surgeon: _____

Most recent physical examination: _____ Purpose: _____

Name of pharmacy/phone/address: _____

Age: _____ Height: _____ Weight: _____

	YES	NO	
1.	☐	☐	Hospitalization for illness or injury (if yes, please explain): _____ _____When: _____
2.	☐	☐	Heart problems, explain: _____
3.	☐	☐	Cardiac stent, if so when was it placed _____
4.	☐	☐	History of Endocarditis (heart infection), if so when _____
5.	☐	☐	Artificial heart valve or repaired heart defect (PFO), if so when _____
6.	☐	☐	Pacemaker or implantable defibrillator, when was it placed? _____
7.	☐	☐	Orthopedic implant (joint replacement). Where on body _____ When_____ Has the implant ever gotten infected after surgery? _____
8.	☐	☐	High blood pressure
9.	☐	☐	Low blood pressure
10.	☐	☐	Stroke? When _____
11.	☐	☐	Anemia or other blood disorder, if so explain _____
12.	☐	☐	Prolonged bleeding due to a slight cut. Do you know your INR? _____
13.	☐	☐	Emphysema, shortness of breath, sarcoidosis (please circle)
14.	☐	☐	Tuberculosis, measles, chicken pox currently (please circle)
15.	☐	☐	Asthma, when was your last hospitalization _____
16.	☐	☐	Breathing or sleep problems like sleep apnea, snoring, sinus issues (please circle)
17.	☐	☐	Kidney disease, if so what stage _____
18.	☐	☐	On dialysis, if so, what days do you go? _____
19.	☐	☐	Liver disease
20.	☐	☐	Thyroid, parathyroid disease, or calcium deficiency (please circle)
21.	☐	☐	Hormone deficiency, explain _____
22.	☐	☐	High cholesterol or taking statin drugs
23.	☐	☐	Diabetes (“Sugar”) A1C#_____ Date of last A1C test _____
24.	☐	☐	Stomach or duodenal ulcer
25.	☐	☐	Digestive disorders (i.e., celiac disease, gastric reflux), explain _____
26.	☐	☐	Gastric bypass/sleeve, when _____
27.	☐	☐	Osteoporosis / osteopenia (i.e., taking bisphosphonates) ☐ IV ☐ Pills When was your last dose? _____ How long were you on the meds? _____
28.	☐	☐	Arthritis
29.	☐	☐	Autoimmune disease (i.e., rheumatoid arthritis, lupus, scleroderma). Explain _____
30.	☐	☐	Head or neck injury
31.	☐	☐	Epilepsy, convulsions (seizures): _____
32.	☐	☐	Neurologic disorders like ADD, ADHD, prion disease, Explain_____

33. ☐ ☐ Cold sores
34. ☐ ☐ Any lumps or swelling in the mouth? Where? _____
35. ☐ ☐ Hives, skin rash, hay fever
36. ☐ ☐ STD/STI/HPV, Explain _____
37. ☐ ☐ Hepatitis? Please circle type: A, B or C, How Long: _____
38. ☐ ☐ HIV / AIDS (T-cell (CD4) count) _____
39. ☐ ☐ Tumor, abnormal growth, cancer? Explain_____
40. ☐ ☐ Radiation therapy: Area _____ When_____ Frequency_____
41. ☐ ☐ Chemotherapy or immunosuppressive medication, When _____
42. ☐ ☐ Emotional difficulties, explain_____
43. ☐ ☐ Psychiatric treatment, explain: _____
44. ☐ ☐ Antidepressant medications, please list: _____
45. ☐ ☐ Marijuana of any type: How often _____
46. ☐ ☐ Alcohol, how often _____
47. ☐ ☐ Recreational drugs, type: _____ How often _____
48. ☐ ☐ Presently being treated for any other illness not listed
If yes, what is it? _____
49. ☐ ☐ Aware of a change in your health in the last 24 hours (i.e., fever, chills, cough, diarrhea)
50. ☐ ☐ Taking medications for weight management, list _____
51. ☐ ☐ Taking dietary supplements, list _____
52. ☐ ☐ Under care of pain management clinic/doctor? Name and # _____
53. ☐ ☐ Experiencing frequent headaches
54. ☐ ☐ A tobacco smoker/vaper/E-cigarette. How many or how much per day? _____
55. ☐ ☐ Chewing tobacco or tobacco product of any kind, for how long _____
56. ☐ ☐ Taking birth control pills
57. ☐ ☐ Currently pregnant or think you may be pregnant
58. ☐ ☐ Taking medication for erectile dysfunction (i.e., Viagra, Cialis, or other medication)
59. ☐ ☐ Taking blood thinners: Type _____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Local Anesthetic
☐ Ibuprofen (Advil/Motrin)	☐ Erythromycin	☐ Fluoride
☐ Acetaminophen (Tylenol)	☐ Tetracycline	☐ Metals (Nickel, Gold, Silver)
☐ Codeine	☐ Sulfa	☐ Latex

☐ Other _____

List all other medications, supplements, and or vitamins taken <u>currently</u> (use additional pages if necessary).

Drug/Dosage/Time of Day	Purpose	Drug/Dosage/Time of Day	Purpose

_____ _____

Signature of Patient or Legal Representative **Date**