LeCroy Dental Arts Patient Medical History

Patient Name: _____ **Birthday:** ___/___/_____

Gender: Male / Female

Are you currently being treated for medical issues? Yes No

If yes, please explain:

Hospitalized or had a major operation within the past 5 years? Yes No

If yes:

Have you had a serious head or neck injury? Yes No

If yes:

Do you use tobacco? Yes No

Do you take blood thinner? such as Coumadin, Plavix, Xarelto, Eliquis, Pradaxa? Yes No

Women: are you

Pregnant Nursing Taking Birth Control

Please circle all conditions that apply to you:

Abnormal Bleeding	Acid Reflux
Alcohol Abuse	Seasonal Allergies / Sinus problems
Alzheimer's Disease	Anemia
Angina Pectoris	Arthritis / Rheumatism
Artificial Heart Valve	Asthma
Blood Transfusion	Blood Disease
Colitis	Congenital Heart Defect
Cancer	Chemotherapy
Diabetes	Difficult Breathing
Drug Abuse	Emphysema
Epilepsy	Fainting Spells
Fever Blisters	Frequent Headaches
HIV + AIDS	Heart Attack / Issues
Glaucoma	Hemophilia
Hepatitis A	Hepatitis B
Hepatitis C	High Blood Pressure
Joint Replacement	Kidney Problems
Liver Diseases	Low Blood Pressure
Lung Disease	Mitral Valve Prolapse
Osteoporosis	Pace-Maker
Radiation Therapy	Rheumatic Fever
Seizures	Cholesterol Issues
Stroke	Thyroid Problem
Tuberculosis	Ulcers

Please circle your Allergies:

Aspirin	Acrylic
Codeine	Dental Anesthetics
Erythromycin	Jewelry
Latex	Metals
Penicillin / Amoxicillin	Sulfa
Tetracycline	Other:_____

Preferred Pharmacy and Location

_____

Who may we contact in case of an emergency?

Name: Contact info:

Please list your current medications:

Is there any disease, condition, or problem that you think this office should know about that is not covered above?

Signature: _____ **Date:**_____