**Tanya P. Lawhon, DDS**
**116 S. 4th St**
**Kingsville, Texas 78363**

# Medical History Form

**(P) 361-595-4121**

**Patient Name**:_____ **Date of Birth**:_____ **Patient Phone Number**_____

| | | | | |
|---|---|---|---|---|
| Are you under a physician's care? | Yes | No | If yes | |
| Have you ever been hospitalized or had a major surgery? | Yes | No | If yes | |
| Have you ever had a serious head/neck injury? | Yes | No | If yes | |
| Are you taking any medications, pills or drugs? **List all** | Yes | No | If yes | |
| Do you take, or have you taken Phen-Fen or Redux? | Yes | No | If yes | |
| Have you ever taken Fosamax, Boniva, Actonel or any | Yes | No | If yes | |
| other medications containing bisphosphonates? | Yes | No | If yes | |
| Are you on a special Diet? | Yes | No | If yes | |
| Do you use tobacco? | Yes | No | If yes | |
| Do you use controlled substances? | Yes | No | If yes | |

## What pharmacy do you prefer? _____

**WOMEN**: Are you…?

○ Pregnant/Trying to get Pregnant ○ Nursing ○ Taking oral contraceptives

**Allergic to any of the following:**

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Sulfa Drugs
○ Local Anesthetics ○ Other

**Do you have, or have you had any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Heart Murmur | Yes | No |
| Alzheimer's Disease | Yes | No | Heart Pacemaker | Yes | No |
| Anaphylaxis | Yes | No | Heart Trouble/Disease | Yes | No |
| Anemia | Yes | No | Hemophilia | Yes | No |
| Angina | Yes | No | Hepatitis A | Yes | No |
| Arthritis/Gout | Yes | No | Hepatitis B or C | Yes | No |
| Artificial Heart Valve | Yes | No | Herpes | Yes | No |
| Artificial Joint | Yes | No | High Blood Pressure | Yes | No |
| Asthma | Yes | No | High Cholesterol | Yes | No |
| Blood Disease | Yes | No | Hives or Rash | Yes | No |
| Blood Transfusion | Yes | No | Hypoglycemia | Yes | No |
| Breathing Problems | Yes | No | Irregular Heartbeat | Yes | No |
| Bruise Easily | Yes | No | Kidney Problems | Yes | No |
| Cancer | Yes | No | Leukemia | Yes | No |
| Chemotherapy | Yes | No | Liver Disease | Yes | No |
| Chest Pains | Yes | No | Low Blood Pressure | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Lung Disease | Yes | No |
| Congenital Heart Disorder | Yes | No | Mitral Valve Prolapse | Yes | No |
| Convulsions | Yes | No | Osteoporosis | Yes | No |
| Cortisone Medicine | Yes | No | Pain in Jaw Joint | Yes | No |
| Diabetes | Yes | No | Parathyroid Disease | Yes | No |
| Drug Addictions | Yes | No | Psychiatric Care | Yes | No |
| Easily Winded | Yes | No | Radiation Treatments | Yes | No |
| Emphysema | Yes | No | Recent Weight Loss | Yes | No |
| Epilepsy or Seizures | Yes | No | Renal Dialysis | Yes | No |
| Excessive Bleeding | Yes | No | Rheumatic Fever | Yes | No |
| Excessive Thirst | Yes | No | Rheumatism | Yes | No |
| Fainting Spells/Dizziness | Yes | No | Scarlet Fever | Yes | No |
| Frequent Cough | Yes | No | Shingles | Yes | No |
| Frequent Diarrhea | Yes | No | Sickle Cell Disease | Yes | No |
| Frequent Headaches | Yes | No | Sinus Trouble | Yes | No |
| Genital Herpes | Yes | No | Spina Bifida | Yes | No |
| Glaucoma | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Hay Fever | Yes | No | Stroke | Yes | No |
| Heart Attack/Failure | Yes | No | Swelling of Limbs | Yes | No |

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| | | | | | |
|---|---|---|---|---|---|
| Thyroid Disease | Yes | No | Ulcers | Yes | No |
| Tonsillitis | Yes | No | Venereal Disease | Yes | No |
| Tuberculosis | Yes | No | Yellow Jaundice | Yes | No |
| Tumors or Growths | Yes | No | | | |

**Have you ever had any serious illness that is not listed above?** Yes No

**Comments:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature** **Date**