LASKA DENTAL LLC

PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION

Patient Name

DOB

Phone

Email

Emergency Contact

Relationship

Emergency Phone

Physician

Physician Phone

ALLERGIES

- ☐ **Penicillin**
- ☐ **Amoxicillin**
- ☐ **Sulfa**
- ☐ **Aspirin**
- ☐ **Ibuprofen**
- ☐ **Codeine**
- ☐ **Latex**
- ☐ **Local Anesthetic**
- ☐ **Metals**
- ☐ **Acrylics**
- ☐ **Foods**
- ☐ **Flavorings**

Other

Reaction(s)

MEDICAL CONDITIONS

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ Artificial Valve
- ☐ Congestive heart failure
- ☐ Arrhythmia
- ☐ Asthma
- ☐ COPD/Lung Disease
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Autoimmune Disorder
- ☐ GERD
- ☐ Ulcers
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Seizures
- ☐ Epilepsy
- ☐ Migraines
- ☐ Anxiety
- ☐ Depression
- ☐ Glaucoma
- ☐ Hearing Disorder

CURRENT MEDICATIONS AND SUPPLEMENTS

PATIENT HEALTH HISTORY (CONTINUED)

PREGNANCY & WOMEN'S HEALTH

Currently Pregnant? **Yes** **No**

If yes, how many weeks? _____

Currently Nursing? **Yes** **No**

HEALTH QUESTIONS

Are you under a physician's care?	☐ Yes	☐ No
Have you been hospitalized in the past?	☐ Yes	☐ No
Any surgeries in the past?	☐ Yes	☐ No
Do you need antibiotics before treatment?	☐ Yes	☐ No
Do you have problems with anesthesia?	☐ Yes	☐ No
Are you taking any blood thinners?	☐ Yes	☐ No
Do you have any joint replacements?	☐ Yes	☐ No
Have you had any organ transplants?	☐ Yes	☐ No
Do you receive any IV infusions?	☐ Yes	☐ No
Do you use a vape/e-cigarettes, tobacco or marijuana?	☐ Yes	☐ No
Do you drink alcohol regularly or use drugs?	☐ Yes	☐ No
Are you taking Bisphosphonate medications? (ex: Fosamax/Prolia	☐ Yes	☐ No

ADDITIONAL MEDICAL INFORMATION

REASON FOR TODAY'S VISIT

PATIENT CERTIFICATION

I certify that the information provided is accurate and complete to the best of my knowledge.

Signature: _____ Printed Name: _____ Date: _____