LAM, WELKIE,
& ASSOCIATES
FAMILY AND COSMETIC DENTISTRY

244 ADELIA ST.
MIDDLETOWN, PA 17057
717-944-3311
OFFICE@LAMANDWELKIE.COM

MEDICAL HISTORY

PHYSICAN'S NAME: PHONE:

DATE OF YOUR LAST PHYSICAL EXAM?

PLEASE LIST CURRENT MEDICATIONS:

DO YOU PRE-MEDICATION PRIOR TO DENTAL APPOINTMENTS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

HAVE YOU BEEN A PATIENT IN A HOSPITAL IN THE PAST FIVE YEARS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

HAVE YOU EVER HAD ANY SURGERIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

HEART (SURGERY, DISEASE, ATTACK)	☐ YES ☐ NO	SUBSTANCE ABUSE	☐ YES ☐ NO
HEART PACEMAKER/ DEFIBRILLATOR	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	THYROID PROBLEMS	☐ YES ☐ NO
ARTIFICIAL HEART VALVE	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO
STROKE / TIA	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
HISTORY OF ENDOCARDITIS	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
ARTIFICIAL JOINTS (HIP, KNEE ETC.)	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO
ARTHRITIS/RHEUMATISM	☐ YES ☐ NO	LATEX SENSITIVITY	☐ YES ☐ NO
KIDNEY DISEASE	☐ YES ☐ NO	ALLERGIES OR HIVES	☐ YES ☐ NO
BONE DENSITY DRUGS, OSTEOPOROSIS	☐ YES ☐ NO	SINUS TROUBLE	☐ YES ☐ NO
SEXUALLY TRANSMITTED DISEASE	☐ YES ☐ NO	RADIATION THERAPY, CHEMOTHERAPY	☐ YES ☐ NO
COLD SORES/FEVER BLISTERS	☐ YES ☐ NO	CANCER, TUMOR	☐ YES ☐ NO
AIDS,HIV	☐ YES ☐ NO	TOBACCO USE	☐ YES ☐ NO
SLEEP APNEA	☐ YES ☐ NO	EPILEPSY OR SEIZURES	☐ YES ☐ NO
HEMOPHILIA, BLEEDING PROBLEMS	☐ YES ☐ NO	PSYCHIATRIC/PSYCHOLOGICAL CARE	☐ YES ☐ NO
LIVER DISEASE	☐ YES ☐ NO	DIZZINESS, FAINTING, VERTIGO	☐ YES ☐ NO
HEPATITIS A, B, OR C	☐ YES ☐ NO	ON BLOOD THINNERS	☐ YES ☐ NO
WOMEN ONLY: ARE YOU PREGNANT?	☐ YES ☐ NO	IF YES, DUE DATE?	

WOMEN ONLY: ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DENTIST OF ANY CHANGE IN MY HEALTH OR MEDICATION.
CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE THE DOCTOR OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS.

2. UPON SUCH DIAGNOSIS, I AUTHORIZE THE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON MYSELF AND TO EMPLOY SUCH ASSISTANCE AS REQUIRED TO PROVIDE PROPER CARE.

PRINT NAME:

SIGNATURE: DATE:

WITNESS: