Steven S. Lawson DDS INC
Creating Healthy Smiles
3579 Oro Dam Boulevard East, Suite C Oroville, California 95966 (530) 534-8353 www.stevelawsondds.com

Confidential Health History

Name_____Date of Birth_____

Yes No Are you aware of an allergy or adverse reaction to any medication or substance? LIST IN BOX BELOW.

Yes No Is your health good?
Yes No Are you being treated by a physician now? (other than routine check-up)
For? _____
Yes No Are you in pain now?
Yes No Have you been in the hospital or ER in the last 3 years?
For? _____
Yes No Have you ever had endocarditis? When? _____

Women:

Yes No Are you pregnant or think you could be pregnant?
Yes No Are you nursing?
Yes No Are you taking birth control pills?

Medications

List over the counter also

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you had?

Heart (surgery, disease, attack)	Yes No	Blood Transfusions	Yes No	Thyroid Problems	Yes No
Chest Pain	Yes No	Hemophilia or Bleeding Problems	Yes No	Glaucoma	Yes No
Congenital Heart Disease	Yes No	Sickle Cell Disease	Yes No	Emphysema	Yes No
Heart Murmur	Yes No	Bruise Easily	Yes No	Chronic Cough or Bleeding Coughs	Yes No
High or Low Blood Pressure	Yes No	Liver Disease or Yellow Jaundice	Yes No	Tuberculosis	Yes No
Mitral Valve Prolapse	Yes No	Neurological Disorders	Yes No	Asthma or Allergies or Hives	Yes No
Artificial Heart Valve or Pacemaker	Yes No	Fainting, Dizzy Spells or Headaches	Yes No	Kidney Problems	Yes No
Rheumatic Fever	Yes No	Nervous or Anxious	Yes No	Latex Sensitivity	Yes No
Arthritis or Rheumatism	Yes No	Tobacco Use	Yes No	Sinus Problems	Yes No
Steroids use	Yes No	Radiation Therapy	Yes No	**HAVE YOU EVER TAKEN:**	
Swollen Ankles	Yes No	Chemotherapy	Yes No	****Fen-Phen/Pondimen/Redux**	Yes No
Stroke or TIA	Yes No	Tumors	Yes No	****Fosamax/Actonel, Boniva**	Yes No
Artificial Joints	**Yes No**	Hepatitis A B C	Yes No		
Ulcers	Yes No	Cold Sores or Canker Sores	Yes No	Medical problem not listed above:	Yes No
Diabetes	Yes No	AIDS or HIV Positive	Yes No	What?	

The practice of dentistry involves treating the whole patient. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. ***I authorize the dentist to contact my physician.***

Physician's Name_____Phone #_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication(s). Further, I will not hold my dentist, or any other member of my dentist's staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

History Review:

Steven Lawson DDS_____Date_____