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Lederman and Lederman, DDS
14575 Bel-Red Road #101
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(425) 746-6020
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Medical History

Health problems you may have or medication you may be taking could have an important interrelationship with the care that You will be receiving. Your answers are for our records and will be considered confidential.

Do you have, or have you had, any of the following:

	Yes	No
Heart Problems	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Emphysema	☐	☐
Blood Pressure Problems (high/low)	☐	☐
Heart Murmur	☐	☐
Heart Valve Problems	☐	☐
Taking Heart Medication	☐	☐
Rheumatic Fever	☐	☐
Heart Attack/Surgery	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Blood Problems	☐	☐
Easy Bruising	☐	☐
Frequent Nose Bleeding	☐	☐
Abnormal Bleeding/Hemophilia	☐	☐
Blood Disease (Anemia)	☐	☐
Ever Require a Blood Transfusion?	☐	☐
Allergy Problems	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Skin Rashes	☐	☐
Taking Allergy Medication	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight Gain or Loss	☐	☐
Special Diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or Bladder Problems	☐	☐
Colitis	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or Neck Pain	☐	☐
Joint Replacement (e.g. total hip, pins or implants)	☐	☐
Fainting Spells, Seizures, Epilepsy	☐	☐
Stroke(s)	☐	☐
Pain or Clicking of Jaw	☐	☐
Frequent or Severe Headaches	☐	☐
Thyroid Problems	☐	☐
Persistent Cough or Swollen Glands	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry often	☐	☐
Family History of Diabetes	☐	☐
Cancer/Tumor	☐	☐
Radiation Treatment	☐	☐
Tuberculosis or Respiratory Disease	☐	☐
Lupus	☐	☐
Hepatitis, Jaundice, or Liver troubles	☐	☐
Herpes or other STD	☐	☐
HIV Positive/AIDS	☐	☐
Rheumatic/Scarlet Fever	☐	☐
Do you consume alcohol?	☐	☐
If Yes, how much	☐	☐
Do you smoke?	☐	☐
If Yes, how much	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses	☐	☐
History of Head Injury	☐	☐
Epilepsy or other Neurological Disease	☐	☐
History of Drug or Alcohol Abuse	☐	☐
History of Mental Health Problems	☐	☐

	Yes	No
DO YOU NEED TO TAKE AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT?	☐	☐

WOMEN

Are you:

Taking Contraceptives/Birth Control Pills	☐	☐
Taking Hormones/Replacement Therapy	☐	☐
Pregnant?	☐	☐
If so, expected delivery date _____		
Nursing?	☐	☐
Have you reached menopause?	☐	☐

If so, do you have any symptoms?

_____

_____

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Medical History

Medications and Allergies

During the past 12 months have you taken any of the following

	Yes	No
Antibiotics or Sulfa Drugs	☐	☐
Anticoagulants (e.g. Coumadin, Plavix)	☐	☐
High Blood Pressure Medication	☐	☐
Bone Density drugs (e.g. Boniva, Fosamax)	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart Troubles	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Diet Pills	☐	☐
Nonprescription Drugs/Supplements	☐	☐
Natural Remedies	☐	☐

NOTES_____

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Are you allergic, or reacted adversely to:

	Yes	No
Local Anesthetics ("novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates/Sedatives	☐	☐
Erythromycin	☐	☐
Tetracycline	☐	☐
Aspirin/Acetaminophen or Ibuprofen	☐	☐
Codeine/Demerol/other Narcotics	☐	☐
Reaction to Metals	☐	☐
Latex or Rubber Dam	☐	☐
Sulfites	☐	☐
Nuts	☐	☐

NOTES_____

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I understand the information I have given is important to my dental health, and it is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____/_____/_____

Dentist Initials: _____

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