DR. COURTNEY J. LAM, DMD
FAMILY AND COSMETIC DENTISTRY

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

MEDICAL HISTORY

PATIENT'S NAME:

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: