Lynn Lepak-McSorley, D.D.S.
3615 West Oklahoma Ave.
Milwaukee, WI 53215
383-8787

MEDICAL HISTORY

FAMILY PHYSICIAN _____
PHONE NO. _____
CITY _____ STATE _____

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	YES	NO
Are you under a PHYSICIAN'S CARE now?	YES	NO
For what? _____		
Are you PREGNANT	YES	NO
Or do you suspect you may be?	YES	NO
Due date: ____/____/____		
Have you ever had a serious illness or operation?	YES	NO
If so, explain		
Do you SMOKE?	YES	NO

What MEDICATIONS are you currently taking? _____
_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./A.R.C.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Veneral Disease	Alcoholism
Ulcers	Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances?
If so, please list:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any disease, condition, or problem not listed? If so, explain
_____
_____
_____

Is there anything else we should know about your health that we have not covered in this form? _____

Do you have any questions or concerns	YES	NO
Would you like to speak to the Doctor privately about any problem?	YES	NO

DENTAL HISTORY

Name of Previous Dentist _____
PHONE NO. _____
CITY _____ STATE _____
Purpose of initial visit _____
_____
Are you aware of a problem? _____
How long since you have seen a dentist? _____
Last **Complete** Dental Exam, Date: _____
Last **Full Mouth X-Rays**, Date: _____
Panoramic X-Ray, Date: _____
Bite wing X-Rays, Date: _____

Have you lost any teeth?	YES	NO

Why? _____
_____
How have they been replaced?
- a. Fixed bridge _____
- b. Removable bridge _____
- c. Denture _____

Are you **unhappy** with your dentures?	YES	NO
Do your gums **bleed**, or feel **tender** or **irritated**?	YES	NO
Have you ever had gum treatment or surgery?	YES	NO

What _____
Where _____
When _____
Are your teeth **sensitive** to hot, cold, sweets, pressure? (circle)

Are you **unhappy** with the **appearance** of your teeth?	YES	NO
Are you aware of **grinding** or **clenching** your teeth?	YES	NO
Do you have **headaches, earaches**, or **neck pains**?	YES	NO
Have you worn **braces** on your teeth? (orthodontics)	YES	NO
Do you have **discolored** teeth that bother you?	YES	NO
Do you **regularly** use **dental floss**?	YES	NO
Are you **apprehensive** about dental treatment?	YES	NO

DOCTOR COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____