

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 _____