Lancaster SMILES
Family & Cosmetic Dentistry

Dr. Michael E. Funk, DMD
2359 Oregon Pike, Suite 102
Lancaster, PA 17601
(717) 394-3592
www.lancastersmilespc.com

MEDICAL HISTORY INFORMATION

Patient Name: _____

Name of Medical Doctor: _____ Phone: ( ) _____

Preferred Pharmacy: _____ Phone: ( ) _____

Do you have or have you ever had any of the following?
Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Epilepsy or Seizures	[ ] High Cholesterol	[ ] Rheumatism
[ ] Anemia	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Angina	[ ] Fainting or Dizziness	[ ] HIV*/AIDS	[ ] Sinus Problems
[ ] Arthritis	[ ] Fever Blisters/Cold Sores	[ ] Joint Replacement	[ ] Stomach Ulcers
[ ] Artificial Joints*	[ ] Frequent Cough	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves*	[ ] Glaucoma	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Heart Disorder (Congenital)*	[ ] Mental Disorders	[ ] Thyroid
[ ] Breathing Problems	[ ] Heart Infection*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis Problems
[ ] Cancer	[ ] Heart Murmur*	[ ] Osteoporosis	[ ] Venereal Disease
[ ] Chemical Dependency	[ ] Heart Pacemaker*	[ ] Radiation Treatment	
[ ] Chemotherapy	[ ] Heart Surgery*	[ ] Respiratory Problems	
[ ] Diabetes	[ ] Hepatitis	[ ] Rheumatic Fever	

*This condition may require antibiotic premedication for certain dental procedures.

Yes	**No**	
[ ]	[ ]	Do you have any health problems that were not listed above or need further clarifications? If yes, please explain: _____
[ ]	[ ]	Are you now under the care of a physician? If yes, please explain: _____
[ ]	[ ]	Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain: _____
[ ]	[ ]	Are you taking any medications or herbals? If yes, please list: _____
[ ]	[ ]	Are you allergic to any medications or substances? Please check appropriate boxes below: [ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Metal [ ] Latex [ ] Sulfa [ ] Other: _____
[ ]	[ ]	Have you used tobacco? How many years? ____ [ ] Cigarettes [ ] Chewing Tobacco [ ] Cigars [ ] Pipe
[ ]	[ ]	Have you ever tested positive to Covid-19? If yes, when: _____

WOMEN (Please check any that apply)
[ ] Pregnant [ ] Nursing [ ] Birth Control

To the best of my knowledge, all of the preceding information is correct. If I have any changes in my health status or medications, I will inform the dentist and staff at the next appointment without fail.

_____ _____ _____

Patient or Legal Guardian Signature Print Name Date