



Leah Olson, DMD

Cosmetic & Family Dentistry

1800 Cooper Point Rd SW #23
 Olympia, WA 98502
 P: (360)352-1330 F: (360) 357-8452
 info@leaholsondmd.com
 leaholsondmd.com

MEDICAL HISTORY

Patient's Name _____	Person Completing Form _____
Medical Alert _____	

Physician's Name _____ Phone # _____

Have you had any medical care within the past two years? Yes No

If yes, please describe _____

Have you taken any medication or drugs during the past two years? Yes No

If yes, please list names and dosage _____

Have you ever taken prescription medications for weight loss (diet pills)? Yes No

If yes, please describe _____

If yes to any of the above, did you have a medical exam for heart issues? Yes No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs? Yes No

Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No

If yes, please specify _____

Have you been a patient in the hospital in the past five years? Yes No

Indicate which of the following you have had or present

- | | | |
|--|---|---|
| Heart (Surgery, Disease, Attack) <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A, B or C..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV Positive..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High/Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve/Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease/Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergy/Hives..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors..... <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had ant disease, condition, or problem not listed? Yes No

If yes, please describe _____

Women: Are you pregnant or think you could be pregnant? Yes No _____ Months Nursing? Yes No

Do you use birth control? Yes No

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. 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 doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist/Employee Reviewing Signature _____ Date _____