MICHAEL G. LAMB D.D.S., P.C.

3337 Hwy. 5 • Douglasville, Georgia 30135

Welcome to our office. It is our sincere hope that your visits here will be comfortable and satisfying. Pleased take a few minutes to complete this confidential questionnaire so that we may serve you.

NAME _____ DATE OF BIRTH _____ AGE _____ HOME PHONE _____

SOC. SEC. # _____ CELL PHONE _____ REFERRED BY _____

RESIDENCE ADDRESS _____ APT _____ CITY _____ ST. _____ ZIP _____ CO. _____

EMPLOYER _____ CITY _____ ST. _____ COUNTY _____

PRESENT POSITION _____ HOW LONG HELD _____ WORK PHONE _____ DEPT. or EXTENS. _____

NAME OF SPOUSE _____ DATE OF BIRTH _____ SOC. SEC. # _____

EMPLOYER _____ CITY _____ ST. _____ COUNTY _____

PRESENT POSITION _____ HOW LONG HELD _____ WORK PHONE _____ DEPT. or EXTENS. _____

WHO WILL PAY FOR THIS ACCOUNT? _____ EMPLOYER _____ PHONE _____

NAME OF INSURED _____ INSURANCE CO. _____ PHONE _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____ ADDRESS _____ PHONE _____

HEALTH HISTORY

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you been advised to pre-medicate with antibiotics prior to dental treatment?	☐	☐
4. Have you ever been hospitalized or had a serious illness or injury?	☐	☐
If yes, explain _____		
5. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously?	☐	☐
6. (women) Are you pregnant? (If so, give due date) _____	☐	☐
7. Do you smoke? If yes, how much _____ Chew Tobacco?	☐	☐
8. Do you use alcoholic beverages? (more than 2 drinks per day)	☐	☐

9. Have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐

SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐

EYES		
Visual change	☐	☐
Glaucoma	☐	☐

EARS		
Loss of Hearing	☐	☐
Ringing in ears	☐	☐

NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐

THROAT		
Soreness/hoarseness	☐	☐

NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions / epilepsy	☐	☐
Numbness / tingling	☐	☐
Dizziness / fainting	☐	☐
Psychiatric treatment	☐	☐

RESPIRATORY	YES	NO
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma / Hay Fever	☐	☐
Persistent cough	☐	☐
Difficulty breathing while lying down	☐	☐

HEART / BLOOD VESSEL		
Mitro Valve Prolapse	☐	☐
Rheumatic fever	☐	☐
Heart Murmur	☐	☐
Chest pain / discomfort	☐	☐
Heart attack / trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Other _____	☐	☐

ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition / goiter	☐	☐
Other _____	☐	☐

BONE / MUSCLES		
Arthritis / rheumatism	☐	☐
Artificial joints	☐	☐

DIGESTIVE SYSTEM	YES	NO
Hepatitis	☐	☐
Jaundice (yellow)	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐

URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Veneral disease	☐	☐
Syphillis	☐	☐
Aids / HIV	☐	☐

BLOOD		
Bleeding tendency	☐	☐
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusions	☐	☐
Blood type A B AB O	*Circle One*	
Rh factor + -	*Circle One*	

OTHER		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐

10. Are you ALLERGIC to any foods, drugs (Penicillin, Codeine, etc) or other medications? ☐ ☐

(CONTINUED ON BACK SIDE)

		YES	NO
11. Are you taking any medication? If yes, please list below:		☐	☐

Name	Dosage	Name	Dosage
1.		4.	
2.		5.	
3.		6.	

12. Is there any disease, condition or problem not listed on the front of this form that you think we should know about or is there any activity your doctor says you cannot do? ☐ ☐
If so, explain ______

13. Physician's Name ______ Physician's Phone No. ______

HEALTH HISTORY

	YES	NO
1. Have you ever had any unfavorable reaction from a local anesthetic (Novocaine)?	☐	☐
2. Have you ever had any serious trouble associated with any previous dental treatment?	☐	☐
3. Does dental treatment make you nervous? ______ Slight ______ Moderate ______ Extremely ______	☐	☐
4. Approx. date of last dental treatment ______, last cleaning ______, last dental x-ray ______		
5. Have you ever been treated for periodontal disease, (gum disease, pyorrhea, trench mouth)? If so, when?	☐	☐
6. Would you like to use Nitrous Oxide (laughing gas) to be more comfortable?	☐	☐
7. Have you ever had one of the following?		

MOUTH	YES	NO	TEETH	YES	NO	ORAL HYGIENE	YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐			
Unpleasant taste / bad breath	☐	☐	Sensitive to hot	☐	☐			
Burning tongue / lips	☐	☐	Sensitive to cold	☐	☐	Brush	☐	☐
Frequent blisters, lips / mouth	☐	☐	Sensitive to sweets	☐	☐	How often ______		
Swelling / lumps in mouth	☐	☐	Sensitive to biting	☐	☐	Dental floss	☐	☐
Ortho treatments (braces)	☐	☐	Food impaction	☐	☐	Fluoride rinse	☐	☐
Biting cheeks / lips	☐	☐	Clenching / grinding	☐	☐	Other ______		
Clicking / popping jaw	☐	☐	Shifting of teeth	☐	☐			
Difficulty closing jaw	☐	☐	Change in bite	☐	☐			

My signature below indicates that I understand and have answered all questions on the medical and dental health history to the best of my knowledge. I request and freely consent to the performance of procedures which are deemed necessary for my dental health care and that these procedures will be discussed with me prior to their taking place. Please remember that payment is required at the time procedures are rendered, unless prior arrangements are made.

Signature ______ Date ______

DATE	BP	PULSE	MEDICAL UPDATES