Thomas R. Lambert, DMD, MAGD
2299 Brodhead Rd, Suite E
Bethlehem, PA 18020
(610) 868-9928

Medical History Update

First Name _____ M.I. _____ Last Name _____ Date _____

Current Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Physician's Name: _____ Phone #: _____

When was your last visit to your physician? _____

When was your last complete physical? _____

Hospitalizations since last visit? _____

Under a physician's care now for: _____

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Exceeding Your Expectations In Everything We Do

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Please tell us if you have had any of the following by checking the appropriate box:

Health History

Do you currently have, or have you ever had, any of the following conditions?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Atopic (Allergy Prone)
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chemical/Substance Dependency
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Ear Congestion
- ☐ Easily Winded
- ☐ Eating Disorders
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Fever Blisters/Cold Sores
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches/Migraines
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rashes
- ☐ Human Papilloma Virus (HPV)
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Limited Jaw Opening
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Mouth Piercings
- ☐ Neck Pain
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgical Implants
- ☐ Swelling of Limbs/Ankles
- ☐ Thyroid Disease
- ☐ Tinnitus/Ringing in Ear
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

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Have you recently started TOBACCO, ALCOHOL, SPECIAL DIET, RECREATIONAL DRUGS? (Please check)

☐ Tobacco ☐ Alcohol ☐ Special Diet ☐ Recreational Drugs

Please list any ALLERGIES TO Drugs, Medications or Anesthetics:

Please list any other MEDICAL CONDITIONS not mentioned above:

Please list all DRUGS/MEDICATIONS that you currently take:

Patient Signature _____ **Date** _____