LeJon M. Carreon, D.D.S.
FAMILY DENTISTRY

PATIENT MEDICAL HISTORY

Thank you for taking the time to fill this form out completely. It will enable us to help you more effectively. If you have any questions at any time, please be sure to ask us. We are always happy to help.

Patient Name: _____ **Date of birth:** _____

Name and Address of Physician: _____

When was your last dental visit? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Are you taking any prescription/over-the-counter drugs? Yes No

If yes, please list each one: _____ _____

_____ _____

Are you allergic to any of the following? ☐ Penicillin ☐ Aspirin ☐ Erythromycin ☐ Latex ☐ Dental Anesthetics ☐ Codeine ☐ Tetracycline

Please list any other drugs that you are allergic to: _____

Have you ever been treated for: (Please check all that apply)

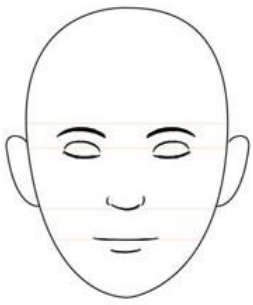
☐ Abnormal Blood Pressure	☐ Heart Attack	☐ Heart surgery	☐ Drug Addiction
☐ Heart Murmur	☐ Congenital Heart Lesions	☐ Artificial Heart Valve	☐ Glaucoma
☐ Heart Pacemaker	☐ Congestive Heart Disease	☐ Stroke	☐ HIV or AIDS
☐ Anemia	☐ Rheumatic Fever	☐ Diabetes	☐ Cancer
☐ Epilepsy	☐ Tuberculosis or Lung Disease	☐ Ulcers	☐ Hemophilia
☐ Sinus Trouble	☐ Asthma	☐ Sleep Apnea	☐ Thyroid Disease
☐ Hepatitis	☐ Artificial Joints or Implants	☐ Kidney Disease	☐ Arthritis
☐ Psychiatric Treatment	☐ Liver Disease	☐ Surgical Stints, Plates or Pins	

Other physical conditions we should be aware of: _____

Do you clench or grind?..... ☐yes ☐no
Are you a tobacco user?..... ☐yes ☐no
Have you ever been treated with radiation?..... ☐yes ☐no
Do you have sensitive teeth?..... ☐yes ☐no
Do you like your smile?..... ☐yes ☐no

We offer botox and dermal fillers

Please mark any areas you would like to address on the face chart to the right:



Women: Are you pregnant?..... ☐yes ☐no
Are you taking birth control pills? ..... ☐yes ☐no

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held at the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature: _____ Date: _____