Health History

Kelly M. Lincoln, DDS
204 E. Federal St. Middleburg, VA 20117
www.MiddleburgSmiles.com

Middleburg Smiles
Kelly M. Lincoln DDS

Do you now have or have you ever had the following?

❑YES ❑NO Severe or Frequent Headaches
❑YES ❑NO High Blood Pressure
❑YES ❑NO Heart Disease / Attack
❑YES ❑NO Hardening of the Arteries
❑YES ❑NO Angina / Chest Pain
❑YES ❑NO Shortness of Breath
❑YES ❑NO Asthma
❑YES ❑NO Emphysema
❑YES ❑NO Heart Surgery
❑YES ❑NO Pacemaker
❑YES ❑NO Congestive Heart Failure
❑YES ❑NO Anorexia / Bulimia
❑YES ❑NO Swelling of the Ankles
❑YES ❑NO Reflux
❑YES ❑NO Abnormal Bleeding
❑YES ❑NO Frequent Nose Bleeds
❑YES ❑NO Blood Disease
❑YES ❑NO Stroke
❑YES ❑NO Anemia
❑YES ❑NO Fainting / Dizziness
❑YES ❑NO Head / Neck Injuries
❑YES ❑NO Dry Mouth

❑YES ❑NO Kidney Disease
❑YES ❑NO Cancer / Tumors
❑YES ❑NO Chemotherapy / Radiation
❑YES ❑NO Thyroid Disease
❑YES ❑NO HIV / AIDS
❑YES ❑NO Shingles
❑YES ❑NO Cold Sores / Fever Blisters
❑YES ❑NO Diabetes
❑YES ❑NO Tuberculosis
❑YES ❑NO Arthritis
❑YES ❑NO Obstructive Sleep Apnea
❑YES ❑NO Artificial Heart Valve
❑YES ❑NO Sinus Trouble
❑YES ❑NO Epilepsy / Seizure
❑YES ❑NO Psychiatric Problems
❑YES ❑NO Depression
❑YES ❑NO Ulcers
❑YES ❑NO Colitis
❑YES ❑NO Hepatitis / Liver Disease
❑YES ❑NO Venereal Disease
❑YES ❑NO Glaucoma
❑YES ❑NO Drug / Alcohol Dependence

_____ _____

_____ _____

Have you ever had an **ALLERGIC** reaction? ❑No ❑Yes If Yes please list allergies:
Include medications, substances, foods, etc.

_____ _____ _____

_____ _____ _____

Continue on other side if needed

Do you consider yourself under an abnormally high amount of stress? ❑Yes ❑No

Do you sleep well? ❑No ❑Yes Have you ever been diagnosed with sleep apnea? ❑No ❑Yes

Have you ever smoked? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Have you ever chewed tobacco? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

WOMEN Are you taking birth control pills? ❑No ❑Yes

Are you pregnant? ❑No ❑Yes - Due date _____

Are you currently nursing? ❑No ❑Yes