Dr. Raymond E. Lawrence, LLC
229 East Center Street
Manchester, CT 06040
(860) 643-0688

Patient's Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Home(___)_____Wk(___)_____Cell(___)_____
Where do you prefer to receive calls:_____
Email: _____

MEDICAL HISTORY

	YES	NO
Are you under medical treatment now?		
Have you been hospitalized for any surgery/illness in the past 6 years?		
If yes, please explain:		
Do you use tobacco?		
If yes, how much and how often?		
Do you consume more than 2 alcoholic beverages per day?		
The following three questions are for women only:		
Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you taking oral contraceptives?		

Are you allergic or have had reactions to any of the following? (please circle)

Penicillin or other antibiotics		*Metals (nickel, mercury, etc.)*
Sulfa drugs	*Aspirin*	*Iodine*
Barbiturates	*Sedatives*	*Latex rubber*
Other (please list)		

Please list ALL medications you are currently taking:

Medication	Dose	Reason

Dental History

	Yes	No
Do your gums bleed while brushing/flossing?		
Are your teeth sensitive to hot or cold?		
Are your teeth sensitive to sweet or sour?		
Do you feel any pain in your teeth?		
Any sores or lumps in or near your mouth?		
Do you have frequent headaches?		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently?		
Have you ever had prolonged bleeding following dental procedures?		
Have you ever had any difficult extractions?		
Have you ever had orthodontic treatment?		
Do you wear dentures/partials? Date of placement?		
Have you ever had to take medication (antibiotics) prior to dental work?		
Are you satisfied with your smile?		

Have you ever experienced any of the following problems in your jaw? (Please circle)

Clicking Difficulty Chewing

Difficulty opening/closing Pain: joint, ear, side of face

Do you have any of the following conditions?

Frequently Tired	Low Blood Pressure	Recent Weight Loss
Epilepsy/Convulsions	Respiratory Problems	Mitral Valve Prolapse
Leukemia	Arthritis	Cancer
Liver Disease	Leukemia	Osteoporosis
Joint Replacement	Diabetes	Kidney Disease
AIDS / HIV Infection	High Cholesterol	Sleep Apnea
Stomach Trouble / Ulcers	Snoring	Thyroid Problem
Chest Pains	Hepatitis	Osteoporosis
High Blood Pressure	Heart Disease	Easily Winded
Cardiac Pacemaker	Heart Attack	Stroke
Hay Fever / Allergies	Rheumatic Fever	Heart Murmur
Swollen Ankles	Angina	Tuberculosis
Fainting/Seizures	Asthma	Anemia
Radiation Therapy	Glaucoma	Emphysema
Other: Please list		

Signature _____ Date:_____