CLEAR CREEK DENTISTRY

Patient Medical Information

Name _____ Date of Birth _____

Emergency Contact _____ Phone _____

Height _____ Weight _____ Physician's Name _____ Phone _____

1. Are you currently under medical care? Why? Y N

_____

2. Have you been hospitalized for any surgical operation or serious illness within the past 5 years? Y N

3. Are you limited in activity because of a physical or medical condition? Y N

4. Please list any medications you are taking. _____

_____

_____

5. Please list any allergies to medications, latex, or metals. _____

_____

6. Have you ever had any serious trouble associated with previous dental treatment or dental anesthetic? Y N

7. Do you use tobacco? *If yes, please list type and history.* Y N

_____

8. Do you use controlled substances? *If yes, please list type and history.* Y N

_____

9. Have you experienced or do you have any of the following medical conditions:

1. Aids/HIV +
2. Anemia
3. Artificial Heart Valve
4. Arthritis
5. Artificial Joints
6. Asthma
7. Back Problems
8. Cancer
9. Chemical Dependency
10. Chemotherapy
11. Chest Pain
12. Circulatory Problems
13. Congenital Heart Lesions
14. Cortisone Treatments
15. Diabetes
16. Diet/Weight Loss
17. Epilepsy/Seizure
18. Fainting/Dizziness
19. Glaucoma
20. Headaches
21. Heart Attack
22. Heart Problems
23. Hepatitis
24. Herpes
25. High Blood Pressure
26. Kidney Disease
27. Liver Disease
28. Lung Disease
29. Nervous Disorder
30. Osteoporosis
31. Antibiotic Premedication
32. Prolonged Bleeding
33. Psychiatric Care
34. Radiation Treatment
35. Sinus Trouble
36. Stroke
37. Swollen Glands
38. Thyroid Problems
39. Tumors or Growths
40. Ulcers/Acid Reflux
41. Sleep Apnea

_____

_____

10. Do you have any other health problems that need further clarification? Y N

WOMEN ONLY –

11. Are you pregnant or think you may be pregnant? Y N **12.** Are you nursing? Y N

13. Are you taking oral contraceptives? Y N

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature _____ Date _____

OFFICE USE ONLY

MEDICAL UPDATES

Date *Changes*

BP _____ **P** _____

_____

_____

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