

231 Main Street, Ben Lomond, CA 95005 (831)336-2261 (Fax)336-5600 [www.creechdental.com](http://www.creechdental.com)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

**Medical Health History**

Your Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious Illnesses or Operations?  Yes  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?  Yes /  No approximate due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing?  Yes /  No Are you taking birth control or Hormones?  Yes /  No

Check box if you have or have had any of the following:

Allergies/Hives

Anemia

Arthritis, Rheumatism

Artificial heart valves

Artificial joints/pins

Asthma

Bleeding abnormally after extraction/surgery

Blood Pressure High/Low

Breathing/Sinus problems (Sleep Apnea)

Cancer

Chemical/Alcohol Dependency

Chemo/Radiation therapy

Circulatory problems

Diabetes

Epilepsy/Seizures

Fainting

Headache/Migraines

Heart murmur/ problems

Hemophilia

Hepatitis

Herpes/Cold sores

HIV/AIDS

Jaw pain

Kidney/ Liver disease

Mitral valve prolapse

Neurologic condition

Pacemaker

Rheumatic/ Scarlet fever

Stroke

Thyroid problems

Tobacco use

Tuberculosis

Are you allergic to, or have you reacted adversely to any of the following?

Latex materials

Penicillin or other antibiotics

Local anesthetics (“Novocaine”)

Codeine or other narcotics

Sulfa drugs

Barbiturates, sedatives, or sleeping pills

Aspirin

Other:

Are you taking any of the following?

Aspirin

Anticoagulants (blood thinners)

Antibiotics or Sulfa drugs – Pre Med.

High blood pressure meds

Antidepressants or tranquilizers

Insulin, Orinase, or other diabetes drugs

Nitroglycerin

Cortisone or other steroids

Osteoporosis (bone density) medicine

Other:

Continued on back…

List additional medications you are currently taking and the correlating diagnosis:

Medication Diagnosis

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Anything else you would like us to know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_