

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

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