CAMAS DENTISTRY

Patient Medical Information

Patient's First and Last Name_____

Date of Last Physical Exam_____Physician's Name and/or Clinic Name_____
Physician's Phone # _____

Patient's Medical History

1. Are you under medical treatment now?.....YES NO

   If so, what?_____

2. Have you been hospitalized for any surgical operations or serious illness?.....YES NO

   If so, what?_____

3. Are you taking any medicines including non-prescription medicine?.....YES NO

   If so, what?_____

Allergies to Medicines _____□ No Known Allergies

Are you allergic to or have you had any reactions to the following?

□ Local Anesthetics (i.e. Novocaine): □ Sulfa Drugs □ Codeine □ Latex □ Sedatives

□ Penicillin / Amoxicillin : □ Ibuprofen □ Barbiturates □ Aspirin

□ Other _____

Please check the boxes if you have or have had any of the following

□ Joint Replacement / Implants / Screws / Pins	□ Anemia	□ Cancer / Radiation Therapy
□ Mitral Valve Prolapse	□ Emphysema	□ Kidney / Liver Disease
□ Heart Murmur	□ Cardiac Pacemaker	□ Angina / Chest Pains
□ Heart Attack / Heart Disease	□ Rheumatic Fever	□ Hepatitis / Jaundice
□ High Blood Pressure	□ Fainting / Seizures	□ Epilepsy / Convulsions
□ Low Blood Pressure	□ Recent Weight Loss	□ Leukemia
□ Asthma	□ Diabetes	□ Thyroid Problems
□ Respiratory Problems	□ Tumors or Growths	□ Stomach Troubles / Ulcers
□ Stroke	□ Hay Fever / Seasonal Allergies	□ Intestinal Disease
□ Tuberculosis	□ Weight Reduction Surgery	□ AIDS / HIV Infection

□ Night Sweats accompanied by weight loss or cough

□ Wounds that heal slowly or present with other complications

□ Have you been treated for Alcohol or Chemical dependency?

Women Only: □ Pregnant or think you may be pregnant □ Nursing □ Taking Birth Control Pills

What is your main reason for visiting Camas Dentistry?_____

Patient/Guardian Signature:_____Date:___/___/___

Dentist's Signature:_____ Date:___/___/___