

**Camas Dentistry
Patient's Medical Information**

Patient's Name _____ Date of Last Physical Exam _____

Physician's 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. Novocain) 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

- | | | |
|--|--|---|
| <input type="checkbox"/> Joint Replacement / Implants / Screws / Pins | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer / Radiation Therapy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney / Liver Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Angina / Chest Pains |
| <input type="checkbox"/> Heart Attack / Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis / Jaundice |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> Epilepsy / Convulsions |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Stomach Troubles / Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hay Fever / Seasonal Allergies | <input type="checkbox"/> Intestinal Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Weight Reduction Surgery | <input type="checkbox"/> AIDS / HIV Infection |
| <input type="checkbox"/> Night Sweats accompanied by weight loss or cough | <input type="checkbox"/> Wounds that heal slowly or present with other complications | |
| <input type="checkbox"/> 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: _____