MEDICAL HISTORY

Cottonwood Creek DENTAL

Name:

Physicians Name: Office phone:

Are you currently under the care of a physician? O Y O N

If yes please explain:

Are you taking any prescription / over the counter medication? O Y O N

Please list all medications:

Do you smoke or use tobacco in any other form? O Y O N Are you taking birth control pills ? O Y O N

Are you pregnant? O Y O N If yes, week # Are you nursing? O Y O N

Have you had a knee or hip replacement that requires antibiotics before dental treatment? O Y O N

Pre-medication recommended by your physician:

Have you ever had any of the following diseases or medical problems?

O Y O N Abnormal Bleeding
O Y O N Alcohol / Drug Abuse
O Y O N Anemia
O Y O N Arthritis
O Y O N Artificial Joints / Heart Valves / Bones
O Y O N Asthma
O Y O N Kidney Problems
O Y O N Blood Transfusions
O Y O N Cancer / Chemotherapy
O Y O N Colitis
O Y O N Congenital Heart Defect
O Y O N Diabetes
O Y O N Difficulty Breathing
O Y O N Emphysema
O Y O N Rheumatic / Scarlet Fever
O Y O N Epilepsy
O Y O N Fainting Spells
O Y O N Frequent Headaches
O Y O N Glaucoma
O Y O N Hay Fever
O Y O N Heart Attack
O Y O N Heart Surgery
O Y O N Hemophilia
O Y O N Hepatitis
O Y O N Herpes / Fever Blisters
O Y O N High Blood Pressure
O Y O N HIV / AIDS
O Y O N Hospitalized for any reason
O Y O N Liver Disease
O Y O N Low Blood Pressure
O Y O N Mitral Valve Prolapse
O Y O N Pacemaker
O Y O N Psychiatric Problems
O Y O N Radiation Treatment
O Y O N Seizures
O Y O N Shingles
O Y O N Sickle Cell Disease
O Y O N Sinus Problems
O Y O N Stroke
O Y O N Thyroid Problems
O Y O N Tuberculosis (TB)
O Y O N Ulcers

Are you allergic to any of the following medications?

O Y O N Aspirin
O Y O N Codeine
O Y O N Dental Anesthetics
O Y O N Erythromycin
O Y O N Latex
O Y O N Penicillin
O Y O N Tetracycline
O Y O N Other

For Doctor Use Only

BP : /

Date

Date

Date

Date

Date

Please list any serious medical condition(s) / Surgeries that you have ever had:

Informed Consent

I understand that the information I have listed above is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical history. I authorize the dental team of Cottonwood Creek Dental to perform any necessary dental treatment that I may need with my informed consent. I understand that during and following dental treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. In addition, I consent that photographs of my treatment may be used for teaching and educational purposes. This consent is in force indefinitely unless revoked in writing by Cottonwood Creek Dental.

Signature

Date

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