Medical History Update

Please complete all sections. Indicate **N/A** if not applicable.

Patient Information

Name: _____
First Last Middle Initial

Date of Birth: _____/_____/_____
DD / MM / YYYY

Address: _____
Street City Postal Code Province

Preferred Language:
- ☐ English
- ☐ Spanish

Phone Number: _____
Cell Home Business

Email: _____

Gender:
- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Prefer not to say

Emergency Contact: _____ Phone Number: _____

Medical Information

Have you, currently or ever received treatment for the following conditions? Please check all that apply:

- ☐ Arthritis
- ☐ Asthma/Breathing Problems
- ☐ Bleeding Disorder/Problem
- ☐ Cancer
- ☐ Chest pain/Angina
- ☐ Diabetes
- ☐ Drug/Alcohol Dependency
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Surgery/Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Malignant Hypothermia
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Osteoporosis Medications
- ☐ Pacemaker'
- ☐ Rheumatic Fever
- ☐ Seizure (Epilepsy)
- ☐ Shortness of Breath
- ☐ Steroid Therapy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ No Medical Concerns
- ☐ Other: _____

Please list any medications (with dosage), supplements, or vitamins you are currently taking:

_____

Are you allergic to any of the following:
- ☐ Penicillin
- ☐ Codeine
- ☐ Aspirin (ASA)
- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Other
- ☐ No known allergies

If you chose **other,** please list what you are allergic to:

_____

_____

				If **yes**, please explain:	
Have you ever had a serious illness or operation?	☐ Yes	☐ No		_____	
Have you been hospitalized in the last 2 years?	☐ Yes	☐ No		_____	
Any changes to your health in the past 1 year?	☐ Yes	☐ No		_____	
Has your doctor advised pre-medications?	☐ Yes	☐ No		_____	
For women: Are you pregnant?	☐ Yes	☐ No	☐ N/A	Due Date: _____	
For women: Are you breastfeeding?	☐ Yes	☐ No	☐ N/A		

Patient Certification and Consent

I, as the undersigned, certify that all the above medical and dental information is true to the best of my knowledge. I understand that photographs may be taken for medical, educational, or research purposes. I hereby consent to the use of such photographs. I have been advised that Creekside Dental Care requires 24 business hours' notice to make changes to existing appointments, otherwise I may be subject to a **$50** broken appointment fee – depending on emergency and unforeseen circumstances.

_____ _____

Patient/Guardian Signature Date Signed