PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
greenvalleydentalcare.com

Medical History

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Emergency Contact:_____

Name & phone number of current physician:_____

1. When was your last physical examination?_____

2. Are you currently taking any medications/supplements/drugs/herbal supplements? **YES** **NO**

If yes, please list name, frequency, and dose: _____

_____

_____

_____

3. Have you ever had surgery, or are any surgeries planned? **YES** **NO**

If yes, please describe: _____

4. Do you have a history of nervous disorders? **YES** **NO** If yes, describe:_____

5. Please check if you are allergic or sensitive to any of the following: ☐ **Penicillin** ☐ **Nuts**(type:_____) ☐ **Codeine** ☐ **Local Anesthetic** ☐ **Latex** ☐ **Other**_____

6. Do you use any of the following tobacco products? **YES** **NO** If **yes**, please circle below and indicate how often**:**

☐ cigarettes _____ ☐ e-cigarettes _____

☐ cigars _____ ☐ snuff/chewing tobacco _____

☐ pipe tobacco _____

7. Do you have diabetes? **YES** **NO**

If yes, please describe/check: ☐ Type 1 ☐ Type 2 Last A1c **date & level**: _____

8. Do you take "pre-medication" prior to dental treatment? **YES** **NO**

If yes, describe: _____

9. Have you had any other serious illness, hospitalization, or accident? **YES** **NO**

If yes, please describe: _____

Are you currently being treated for any ongoing medical conditions not mentioned above?

_____

Women Only:

Are you pregnant or trying to get pregnant? **YES** **NO** How long? _____

Are you currently breastfeeding? **YES** **NO**

Do you take oral contraceptives? **YES** **NO**

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Medical History (con't.)

Patient Name: _____ **DOB:** _____

10. Please circle below if you have, or have ever had, any of the following:

Heart trouble	**Yes**	**No**	Thyroid problem	**Yes**	**No**
Heart murmur	**Yes**	**No**	Jaundice	**Yes**	**No**
Heart Surgery	**Yes**	**No**	Hepatitis (type:___)	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**	Leukemia	**Yes**	**No**
Congenital heart defects	**Yes**	**No**	Cancer	**Yes**	**No**
Artificial heart valve/stent/graft	**Yes**	**No**	Chemotherapy/radiation treatment	**Yes**	**No**
Abnormal blood pressure	**Yes**	**No**	Arthritis	**Yes**	**No**
Stroke	**Yes**	**No**	Artificial joint replacements	**Yes**	**No**
Ulcers/GERD	**Yes**	**No**	Cortico-Steroid treatment	**Yes**	**No**
Kidney trouble/Dialysis	**Yes**	**No**	Oral herpetic lesions	**Yes**	**No**
Tuberculosis or lung disease	**Yes**	**No**	Psychiatric Care	**Yes**	**No**
Asthma	**Yes**	**No**	Glaucoma	**Yes**	**No**
Epilepsy/Seizures	**Yes**	**No**	Hearing Impaired	**Yes**	**No**
Fainting Spells	**Yes**	**No**	Chemical dependency	**Yes**	**No**
Anemia	**Yes**	**No**	Osteoporosis treatment with Bisphosphonates	**Yes**	**No**
Excessive or prolonged bleeding	**Yes**	**No**			
Pacemaker	**Yes**	**No**			

Please describe any "yes" answers from above:_____
_____
_____

The information you provide is completely confidential and used only to provide you the best care during your dental treatment.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____