Dr. Ray Lanoue

PATIENT MEDICAL INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ POSTAL CODE:_____

PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

CONTACT IN CASE OF EMERGENCY: _____

PHONE:_____

FAMILY PHYSICIAN: _____

DATE OF LAST MEDICAL CHECK UP:_____

SPECIALIST:_____

HEATH CARD # _____ -_____-_____-_____

S.I.N. # _____ - _____ - _____

HAVE YOU EVER HAD, OR DO YOU HAVE ANY OF THE FOLLOWING

THYROID DISEASE	YES / NO	**LUNG DISEASE**	YES / NO
DIABETES	YES / NO	**KIDNEY DISEASE**	YES / NO
HEART ATTACK	YES / NO	**ASTHMA**	YES / NO
STROKE	YES / NO	**EPILEPSY/CONVULSIONS**	YES / NO
HEART MURMUR	YES / NO	**HIV/AIDS**	YES / NO
HEART DISEASE	YES / NO	**OSTEOPOROSIS**	YES / NO
MITRAL-VALVE PROLAPSE	YES / NO	**ARTHRITIS**	YES / NO
BLEEDING DISORDER	YES / NO	**MENTAL DISORDERS**	YES / NO
HEPATITIS A B C	/ NO	**JOINT REPLACEMENT**	YES / NO
HIGH BLOOD PRESSURE	YES / NO	**CHOLESTEROL**	YES / NO
LIVER DISEASE	YES / NO	**OTHER**	YES / NO

CANCER/WHEN/WHAT KIND? :_____

DO YOU NEED TO BE PRE-MEDICATED BEFORE DENTAL APPT YES / NO

DO YOU WEAR A PACEMAKER? YES / NO

ARE YOU PREGNANT? YES / NO

DO YOU SMOKE? YES / NO

ARE YOU NERVOUS FOR DENTAL TREATMENT? YES / NO

ALLERGIES

PENICILLIN	YES / NO	**TETRACYCLINE**	YES / NO
SULFA	YES / NO	**MORPHINE**	YES / NO
LOCAL ANESTHETIC	YES / NO	**LATEX**	YES / NO
CODEINE	YES / NO	**FLUORIDE**	YES / NO
ASPIRIN	YES / NO	**FOODS**	YES / NO

OTHER:_____

MEDICATIONS (PLEASE LIST)

SURGERIES (PLEASE LIST)

SIGNATURE: _____ DATE: _____