GEORGETOWN DENTURE CLINIC

Creating Confident Smiles Since 1982!

905•877•2359

MEDICAL INFORMATION

Name – please print: _____

Emergency contact name: _____Phone No.: _____

Have you ever been treated / or are being treated now for any of the following? Please check only if answer is "yes".

O DIABETES O HEART ISSUES O EPILEPSY O HIGH BLOOD PRESSURE

O ALZHEIMERS / DEMENTIA O PARKINSON'S DISEASE O STROKE

O HIV/AIDS O RESPIRATORY DISEASE O ASTHMA O SLEEP APNEA

O HEPATITIS O COPD O TUBERCULOSIS O REPEAT HEADACHES

PLEASE LIST ANY MEDICATIONS: _____

_____

CANCER – IF YES, PLEASE SPECIFY: _____

ALLERGIES – IF YES, PLEASE LIST: _____

MEDICAL DOCTOR'S NAME: _____

DO YOU SMOKE? O YES O NO

DO YOU SNORE? O YES O NO

HAS ANYOHE EVER SAID THAT YOU STOP
BREATHING OR HAVE PAUSES IN YOUR BREATHING DURING SLEEP? O YES O NO

ANY OTHER MEDICAL ISSUES NOT LISTED: _____

_____

Signature: _____ Date: _____