Medical History

Name: _____ Date: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by the privacy of information act and is for our records only.

In case of emergency we should notify:

Name: _____Relationship: _____ Phone number: _____

Physician's name: _____ Phone number:_____

1. Are you being treated for any medical condition at the present or in the past two years? If so why?
   Yes no not sure
   _____
2. When was your last medical check-up?
   _____
3. Has there been any change in your general health in the past year? If yes please explain.
   Yes no not sure
   _____
4. Are you taking any medications? Please list:
   a. Prescription Medications:
      _____
      _____
   b. Over the counter medications, supplements or herbs
      _____
      _____
5. Do you have allergies? If yes please list using the categories below:
   Yes no not sure
   a. Medications _____
   b. Latex/rubber products _____
   c. Environmental (hayfever, scents) _____
   d. Food _____
6. Have you ever had a bad reaction to any medicines or injections? If yes, please explain.
   Yes no not sure
   _____
7. Do you have or have you ever had asthma, COPD, or other lung disease?
   Yes no not sure
   _____
8. Do you have or have you ever had any heart or blood pressure problems?
   Yes no not sure
   _____

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (infective endocarditis), a heart condition from birth, or a heart transplant?

Yes no not sure

_____

10. Do you have a prosthetic or artificial joint?

Yes no not sure

_____

11. Do you have any conditions or therapies that could affect your immune system e.g. leukemia,AIDS, HIV infection, radiotherapy, chemotherapy?

Yes no not sure

_____

12. Have you ever had hepatitis, jaundice, or liver disease?

Yes no not sure

_____

13. Do you have a bleeding problem or bleeding disorder?

Yes no not sure

_____

14. Are you taking any medications for osteoporosis e.g. Fosamax, Actonel?

Yes no not sure

_____

15. Have you ever been hospitalized for any illness or operations?

Yes no not sure

_____

16. Do you have or have you ever had any of the following? Please check:

Arthritis	Cancer	Chest Pain	Cold Sores (Herpes)
Diabetes	Drug/alcohol dependency	Heart attack	HPV (human papilloma virus)
Kidney disease	Pacemaker	Psychiatric disorder	Seizures
Shortness of breath	Sinus problems	Steroid Therapy	Stomach Ulcers
Stroke	Thyroid disease		

17. Do you have any other conditions or problems not listed above?

Yes no not sure

_____

18. Do you smoke or use other tobacco products? If yes how much?

Yes no

_____

19. Women: Are you pregnant or trying to become pregnant?

Yes no

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Please Print Name: _____