

CONFIDENTIAL MEDICAL HISTORY

Name:..... Birthdate:.....
Address:..... City:..... Postal Code:.....
Home phone:..... Cell phone:..... Work phone:.....
e-mail:..... Preferred contact? Home / Cell / Work / e-mail

- Yes No Please mark (✓) the appropriate answer**
- () () 1. Do you feel nervous having dental treatment?
- () () 2. Are you currently taking any medications or drugs?
Please list :
- () () 3. Are you allergic to or have been made sick by latex, penicillin, aspirin
codeine, local anesthetic, or any other drug or medication? What were
the reactions?.....
- () () 4. Have you had any major surgery or been hospitalized . When and why?
Please list:.....
- () () 5. Are you currently under the care of a medical doctor for any of the
following medical conditions listed?

Please (✓) if it applies to you

- | | |
|---------------------------------|--|
| () heart failure | () thyroid disease |
| () heart disease or attack | () chemotherapy/radiation therapy |
| () angina pectoris | () diabetes |
| () high blood pressure | () arthritis |
| () heart murmur | () rheumatism |
| () rheumatic fever | () cortisone medicine |
| () congenital heart lesions | () glaucoma |
| () scarlet fever | () pain in jaw joints |
| () artificial heart valve | () drug addiction |
| () pacemaker | () AIDS/HIV |
| () heart surgery | () Hepatitis (A, B, C, or other form) |
| () artificial joint/prosthesis | () liver disease/yellow jaundice |
| () anemia | () sickle-cell disease |
| () stroke | () allergies or hives |
| () kidney trouble | () cold sores |
| () ulcers or stomach trouble | () blood transfusion |
| () cancer or tumor | () hemophilia/blood disorders |
| () emphysema | () venereal diseases |
| () bronchitis | () genital herpes |
| () tuberculosis(TB) | () epilepsy or seizures |
| () asthma | () fainting or dizzy spells |
| () sinus trouble | () psychiatric treatment |

NEXT PAGE →

Yes No

- () () 6. Have you ever had any excessive bleeding requiring special treatment?
- () () 7. Have you had surgery or radiation therapy of the head or neck area?
- () () 8. Do you experience chest pain or shortness of breath? Wake up short of breath?
- () () 9. Do your ankles swell during the day?
- () () 10. Have you gained or lost any excessive weight in the past year?
- () () 11. Do you wear contact lenses?
- () () 12. Do you smoke?
- () () 13. Are you aware of any snoring, grinding or clenching at night?
- () () 14. Is there anything else we should know about your health?

.....

WOMEN:

- () () Are you pregnant or anticipate becoming pregnant?
- () () Are you breast feeding?
- () () Are you taking oral contraceptives?

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change I will inform my dentist at the next appointment without fail.

I undertake to pay any dental costs not covered by my dental insurance policy (including any deductibles and percentage of fees not covered)

Date

Signature of patient, parent or guardian

Occupation:

Family Doctor:phone:.....

Referred by:.....

This will form part of our confidential patient record in order to best serve your dental needs. Thank you for your co-operation.