MEDICAL HISTORY

Last Full Med History

____

PERSONAL INFORMATION

Name: ______________________________ ______________________________
Last First

DENTAL HISTORY

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 doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand.

Primary reason for today's visit?____

Date of last dental treatment? ______________________________

Y / N – I feel nervous about coming to the dentist Y / N – I brush my teeth daily Y / N – I floss daily

Y / N – I would describe my current dental health as good Y / N – I think I may have tooth decay

MEDICAL HISTORY

Your Current Family Physician/Doctor: ______________________________ **Phone #:** ________________

Have you ever had the following diseases or medical problems? **PLEASE CIRCLE (YES/NO)**

Y / N ☐ Heart Attack ☐Stroke ☐Heart Disease
Y / N ☐ Artificial Valves ☐Stents/Prostheses
Y / N ☐ Heart Murmur ☐Rheumatic Fever
Y / N ☐ Heart Surgery ☐Pacemaker
Y / N ☐ Congenital Heart Defect ☐Mitral Valve Prolapse
Y / N Sinus Problems: ______________
Y / N ☐ High Blood Pressure ☐ Low Blood Pressure
Y / N Lung: ☐TB ☐Emphysema ☐Asthma ☐COPD
Y / N ☐ Kidney disease ☐ Thyroid______________
Y / N Diabetes Type: ___________
Y / N ☐Liver ☐Hepatitis A or B or C
Y / N ☐ Knee ☐ Hip ☐Ankle ☐Pins ☐Plates
Y / N ☐Anxiety ☐ Depression ☐Psychiatric Disorder
Y / N ☐Epilepsy ☐Seizures ☐Fainting Spells
Y / N ☐Osteoporosis Medication __________

Y / N ☐ Ulcers ☐Colitis ☐ Crohn's
Y / N ☐ Cancer ☐Chemotherapy Date: _____
Y / N ☐ Anemia ☐Radiation Treatment
Y / N Sexually Transmitted Diseases: ________
Y / N ☐ HIV Positive ☐AIDS ☐ Blood Transfusion
Y / N Cold Sores *re-schedule appointments when have
Y / N ☐ Hemophilia ☐Abnormal Bleeding
Y / N ☐ Severe headaches ☐ Frequent Headaches
Y / N ☐ Drug Abuse ☐Alcohol Abuse Past OR Present
Y / N Chewing Tobacco Past OR Present
Y / N ☐ Smoker ☐Vaper Past OR Present
Y / N ☐Prescription Marijuana ☐Cannabis Oil
Y / N Are you taking any oral contraceptives
Y / N Are you pregnant? __________Weeks
Y / N Do you have or ever had Asthma

Y / N Any Other Medical Concerns we should know about? ______________________________
Y / N ☐Jaw Joint Pain ☐Jaw Soreness ☐ Jaw click/crack/pop ?________________________
Y / N Do you presently have: ☐Current Persistent Cough ☐Chronic Diarrhea ☐Undiagnosed Skin Rash
Y / N Have you traveled outside of Canada in last 12 months? Date/Location:________________
Y / N Any medical conditions or surgery that requires you to be pre-medicated prior to dental treatment?________
Y / N Do you drink Grapefruit Juice? If yes how much per week? ______________

Please list any medications/herbal supplements or over the counter medications you are currently taking:

____

ALLERGIES ____
☐Penicillin ☐Codeine ☐Sulfa Drugs ☐Erythromycin ☐ Food ☐Latex ☐Anesthetics ☐Nuts ☐Dairy ☐Other

I acknowledge that all documents will be digitally converted and archived. I recognize the digital archive of my documents as valid legal documents.

Patient/Parent/Guardian Signature: ______________________________ **Date:** ______________