Solar Dental™
The Esthene Centre

MEDICAL HISTORY

Clients Name:

*If you require assistance completing this form please notify the receptionist or your Dental Professional.
*The questions on this form are important to our practice so that our standards of safety, professionalism and treatments can be upheld. Your answers to these questions may affect the types of treatment that are appropriate for your dental health. All of these questions will be held in strict confidentiality.
*If you are completing this form for a child or ward, "you" or "your" always refers to the child or wards medical history.

Medical Physician	Telephone	
Medical Specialist	Telephone	
Emergency Contact	Telephone	Relationship

1. When was your last medical visit and reason?_____	N	Y_____
2. Has there been any notable changes in your health in the last 2 years? Please specify._____	N	Y_____
3. Have you been hospitalized in the last 2 years? Please specify._____	N	Y_____
4. *Do you have any allergies? penicillin, aspirin, codeine, sulpha, anesthetic, other?_____	N	Y_____
If other, please list substance(s) and reaction(s)._____		
5. (Women) Do you believe you are pregnant? Please specify due date._____	N	Y_____
6. (Women) Are you taking birth control pills?_____	N	Y_____
7. Do you use any tobacco substances or use recreational drugs? Frequency/amount._____	N	Y_____
8. Do you have a drug or alcohol dependency?_____	N	Y_____
9. Does your family have a history of malignant hyperthermia?_____	N	Y_____
10. Are you currently taking any prescription, non-prescription or herbal medications? Please list below.	N	Y_____

CONDITIONS	DRUG	DOSAGE	FREQUENCY

ARE YOU PRONE TO:

Fainting	N	Y
Dizzy Spells	N	Y
Loss of consciousness	N	Y
*Epilepsy or seizures	N	Y
*Excessive bleeding	N	Y
Bruising	N	Y

HAVE YOU HAD:

*Organ transplant	N	Y
Heart disease	N	Y
Joint replacement (when/where)_____	N	Y
*Pacemaker	N	Y
*Artificial heart valve implant (when)_____	N	Y

DO YOU HAVE/HAVE YOU EVER HAD:

Learning or Behaviour problems	N	Y
Excessive nervousness	N	Y
Communication problems	N	Y
Sensory disorder	N	Y
Psychiatric conditions	N	Y
Sleep apnea	N	Y
Osteoporosis (fosamax/actonel)	N	Y
Stomach/intestinal disorders	N	Y
Diabetes (Type I or II)	N	Y
*Heart attack (when)_____	N	Y
Angina	N	Y
High cholesterol	N	Y
*Stroke (when)	N	Y
*Blood thining medications (INR)	N	Y
Coronary disease	N	Y
*Scarlet or Rheumatic fever	N	Y
*Coronary Stent/occlusion/other (when)_____	N	Y
*Mitral valve prolapse	N	Y
Heart Murmur	N	Y
*Congential heart trouble/defect	N	Y
Arteriosclerosis	N	Y
*High/low blood pressure	N	Y
Eating disorder	N	Y
Unintentional weight gain/loss	N	Y
*Radiation/Chemotherapy (when)_____	N	Y
Urinary tract infection	N	Y

Kidney disease	N	Y
Blood disorders (anemia/hemophilia)	N	Y
Blood or blood product transfusion	N	Y
Liver disorders	N	Y
Trauma or injury to head or neck	N	Y
Thyroid/glandular disorders	N	Y
Tuberculosis	N	Y
Lung disease	N	Y
Hodgkin's disease	N	Y
Sickle cell disease	N	Y
Pneumonia	N	Y
Cystic fibrosis	N	Y
Asthma	N	Y
Shortness of breath or breathing	N	Y
Hay fever	N	Y
Sinus trouble	N	Y
Allergy to cloves/metal	N	Y
Allergy to latex/plastics/bandages	N	Y
Frequent nose bleeds	N	Y
Arthritis	N	Y
HIV infection	N	Y
Aids/Aids related diseases	N	Y
Hepatitis A, B, C, other	N	Y
Jaundice	N	Y
Herpes-cold sores	N	Y
Parkinson's Disease	N	Y

Do you have any other disease, condition or factors in your medical health/history which was not mentioned above that we should know about. If Yes, please describe;_____

_____

The above Medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical and dental profile.

Patient ☐ Parent ☐ Guardian ☐ Name (Printed)_____

Signature_____ Date_____

Office Notes_____

_____