

MEDICAL HISTORY

Client's 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? _____ If other, please list substance(s) and reaction(s). _____	N	Y
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: DO YOU HAVE/HAVE YOU EVER HAD:

Fainting	N	Y	Learning or Behaviour problems	N	Y	Kidney disease	N	Y
Dizzy Spells	N	Y	Excessive nervousness	N	Y	Blood disorders (anemia/hemophilia)	N	Y
			Communication problems	N	Y	Blood or blood product transfusion	N	Y
Loss of consciousness	N	Y	Sensory disorder	N	Y	Liver disorders	N	Y
			Psychiatric conditions	N	Y	Trauma or injury to head or neck	N	Y
*Epilepsy or seizures	N	Y	Sleep apnea	N	Y	Thyroid/glandular disorders	N	Y
			Osteoporosis (fosamax/actonel)	N	Y	Tuberculosis	N	Y
*Excessive bleeding	N	Y	Stomach/intestinal disorders	N	Y	Lung disease	N	Y
			Diabetes (Type I or II)	N	Y	Hodgkin's disease	N	Y
Bruising	N	Y	*Heart attack (when) _____	N	Y	Sickle cell disease	N	Y
			Angina	N	Y	Pneumonia	N	Y
*Organ transplant	N	Y	High cholesterol	N	Y	Cystic fibrosis	N	Y
			*Stroke (when) _____	N	Y	Asthma	N	Y
Heart disease	N	Y	*Blood thinning medications (INR)	N	Y	Shortness of breath or breathing	N	Y
			Coronary disease	N	Y	Hay fever	N	Y
Joint replacement (when/where) _____	N	Y	*Scarlet or Rheumatic fever	N	Y	Sinus trouble	N	Y
			*Coronary Stent/occlusion/other (when) _____	N	Y	Allergy to cloves/metal	N	Y
*Pacemaker	N	Y	*Mitral valve prolapse	N	Y	Allergy to latex/plastics/bandages	N	Y
			Heart Murmur	N	Y	Frequent nose bleeds	N	Y
*Artificial heart valve implant (when) _____	N	Y	*Congenital heart trouble/defect	N	Y	Arthritis	N	Y
			Arteriosclerosis	N	Y	HIV infection	N	Y
Urinary tract infection	N	Y	*High/low blood pressure	N	Y	Aids/Aids related diseases	N	Y
			Eating disorder	N	Y	Hepatitis A, B, C, other	N	Y
			Unintentional weight gain/loss	N	Y	Jaundice	N	Y
			*Radiation/Chemotherapy (when) _____	N	Y	Herpes-cold sores	N	Y
				N	Y	Parkinson's Disease	N	Y
				N	Y		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 _____