FULL MEDICAL HISTORY

PERSONAL INFORMATION

☐ Male ☐ Female

Name: _____ _____
Last First

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

HOW WOULD YOU LIKE TO CONFIRM YOUR APPOINTMENTS? EMAIL CELL/TEXT HOME **WE USE AN AUTOMATED SYSTEM FOR COMMUNICATIONS**

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Date of Birth: _____ **Emergency Contact (Ph#/Name):** _____
Day Month Year

Employer: _____ **Email:** _____

How did you hear about our office? ☐ **Website** ☐ **YellowPages** ☐ **Family/Friend** ☐ **Co-Worker** ☐ **Location**
☐ **Other/Whom may we thank?** _____

MEDICAL HISTORY

Family Physician/Doctor Name: Dr. _____ **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 ☐ Ulcers ☐ Colitis ☐ Crohns
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 ☐ Present
Y / N Chewing Tobacco: ☐ Past ☐ Present
Y / N ☐ Smoker ☐ Vaper ☐ Past ☐ Present
Y / N ☐ Prescription Marijuana ☐ Cannabis Oil
Y / N Are you taking any oral contraceptives
Y / N Are you pregnant?_____Weeks

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 Are you nervous about or have you had a negative dental experience?_____
Y / N Are you happy with your smile?_____

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

Signing this document I also acknowledge all documents will be digitally converted and archived as such only. All my documents active or achived in digital format I recognize them as valid legal documents."

Patient/Parent/Guardian Signature: _____ **Date:** _____/ 2018