

# MEDICAL 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. Please fill in the entire form.

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

1. Are you currently being treated for any medical condition or have you been treated within the past year?  YES  NO

If so, why? \_\_\_\_\_

2. When was your last medical checkup? \_\_\_\_\_

3. Has there been any change in your general health in the past year? (i.e. unexplained weight, appetite or frequency of urination changes)

YES  NO If so, please explain. \_\_\_\_\_

4. Have you ever been hospitalized for any illnesses or operations?  YES  NO

If so, please explain. \_\_\_\_\_

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?  YES  NO

If so, please list. \_\_\_\_\_

6. Are you on any special diet? (e.g. salt restricted diet). If so, why? \_\_\_\_\_  YES  NO

7. Have you had any antibiotics in the last 3 months? If so, why? \_\_\_\_\_  YES  NO

8. Do you bruise easily or have bleeding problem or bleeding disorder? \_\_\_\_\_  YES  NO

9. Have you ever fainted, had shortness of breath or chest pains? If so, what were the circumstances?  YES  NO

10. Do you suffer from canker sores or cold sores? \_\_\_\_\_  YES  NO

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? \_\_\_\_\_  YES  NO

12. Have you ever had hepatitis, jaundice or liver disease? \_\_\_\_\_  YES  NO

13. Do you have any organ transplants or joint replacements? If so, since when? \_\_\_\_\_  YES  NO

14. Do you have any allergies? Including: Medications, foods, latex, environmental, other?  YES  NO

If so, please list: \_\_\_\_\_

15. Have you ever had an adverse reaction to any of the following. If so, explain: \_\_\_\_\_  YES  NO

**Aspirin** **Penicillin** **Codeine** **Latex** **Dental Freezing** **Other:** \_\_\_\_\_

16. Have you ever had an adverse reaction to metal or metal jewelry? If so, please explain \_\_\_\_\_  YES  NO

17. Have you been told by your medical doctor that you need to take antibiotics before dental treatments?  YES  NO

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

YES  NO If so, please explain: \_\_\_\_\_

19. Do you have or have you ever had asthma? If so, since when? \_\_\_\_\_  YES  NO

20. Do you smoke or chew tobacco products? If so, how many / how often? \_\_\_\_\_  YES  NO