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