

MEDICAL HISTORY

(please note that prior to any dental treatment our office requires a complete medical history. Knowing any health problems and/or medications that you may be taking can avoid problems when treatment commences. Thank you for taking the time to answer these questions)

PATIENT'S NAME _____ DATE OF BIRTH _____

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU BRUISE EASILY?	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR.....	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			11. HAVE YOU HAD A RECENT WEIGHT LOSS?	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME: _____ ADDRESS: _____ PHONE NUMBER: _____			12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	<input type="checkbox"/>	<input type="checkbox"/>	13. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR AN OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE EXPLAIN:			15. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>
.....			16. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>			
IF YES, WHAT MEDICINE(S) ARE YOU TAKING?: _____					
8. HAVE YOU EVER EXPERIENCED ABNORMAL BLEEDING?	<input type="checkbox"/>	<input type="checkbox"/>			

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?..

ARE YOU NURSING?

ARE YOU TAKING BIRTH CONTROL PILLS?

	YES	NO		YES	NO
ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO:			LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANAESTHETICS OR "FREEZING"	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES, OR SLEEPING PILLS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN (ASA)	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
LATEX/RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANAESTHETICS ("freezing" used at the dentist)	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	TONSILITIS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE, OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	TUMOURS	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
			CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
			MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>