CONFIDENTIAL MEDICAL HISTORY

Name:……………………………………………………………………. **Birthdate:**………………………………………..
Address:……………………………..………….… **City:**..……………….…… **Postal Code:**………………………
Home phone:………………………. **Cell phone:**………………………. **Work phone:**………………………..
e-mail:………………………………………………….. **Preferred contact? Home / Cell / Work / e-mail**

Yes	*No*	*Please mark (✓) the appropriate answer*
( )	( )	1. Do you feel nervous having dental treatment?
( )	( )	2. Are you currently taking any medications or drugs? Please list : ………………………………………………. …………………………………………………
( )	( )	3. Are you allergic to or have been made sick by latex, penicillin, aspirin codeine, local anesthetic, or any other drug or medication? What were the reactions?………………………………………………………………………
( )	( )	4. Have you had any major surgery or been hospitalized . When and why? Please list:…………………………………………………………………………… ……………………………………………………………………………
( )	( )	5. Are you currently under the care of a medical doctor for any of the following medical conditions listed?

Please (✓) if it applies to you

( )	heart failure	( )	thyroid disease
( )	heart disease or attack	( )	chemotherapy/radiation therapy
( )	angina pectoris	( )	diabetes
( )	high blood pressure	( )	arthritis
( )	heart murmur	( )	rheumatism
( )	rheumatic fever	( )	cortisone medicine
( )	congenital heart lesions	( )	glaucoma
( )	scarlet fever	( )	pain in jaw joints
( )	artificial heart valve	( )	drug addiction
( )	pacemaker	( )	AIDS/HIV
( )	heart surgery	( )	Hepatitis (A, B, C, or other form)
( )	artificial joint/prosthesis	( )	liver disease/yellow jaundice
( )	anemia	( )	sickle-cell disease
( )	stroke	( )	allergies or hives
( )	kidney trouble	( )	cold sores
( )	ulcers or stomach trouble	( )	blood transfusion
( )	cancer or tumor	( )	hemophilia/blood disorders
( )	emphysema	( )	venereal diseases
( )	bronchitis	( )	genital herpes
( )	tuberculosis(TB)	( )	epilepsy or seizures
( )	asthma	( )	fainting or dizzy spells
( )	sinus trouble	( )	psychiatric treatment

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Yes No

( ) ( ) 6. Have you ever had any excessive bleeding requiring special treatment?

( ) ( ) 7. Have you had surgery or radiation therapy of the head or neck area?

( ) ( ) 8. Do you experience chest pain or shortness of breath? Wake up short of breath?

( ) ( ) 9. Do your ankles swell during the day?

( ) ( ) 10. Have you gained or lost any excessive weight in the past year?

( ) ( ) 11. Do you wear contact lenses?

( ) ( ) 12. Do you smoke?

( ) ( ) 13. Are you aware of any snoring, grinding or clenching at night?

( ) ( ) 14. Is there anything else we should know about your health?

……………………………………………………………………………………………………….

……………………………………………………………………………………………………….

WOMEN:

( ) ( ) Are you pregnant or anticipate becoming pregnant?

( ) ( ) Are you breast feeding?

( ) ( ) Are you taking oral contraceptives?

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change I will inform my dentist at the next appointment without fail.
I undertake to pay any dental costs not covered by my dental insurance policy (including any deductibles and percentage of fees not covered)

Date Signature of patient, parent or guardian

Occupation: ……………………………………………………………………………………………….

Family Doctor: …………………………………………phone:…………………………………………….

Referred by:…………………………………………………………………………………………………

This will form part of our confidential patient record in order to best serve your dental needs. Thank you for your co-operation.