CONFIDENTIAL MEDICAL HISTORY

Patient Name _____ Preferred Name_____ Age_____

Name of Physician_____ Phone # _____

Name of Medical Specialist_____ Area of Specialty _____ Phone # _____
(if presently under care)

Date of last visit to a physician_____ Reason_____ Date of last complete physical _____

What is your estimate of your general health? _____

INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY TO YOU PRESENTLY OR IN THE PAST:

	YES	NO
1. hospitalization for illness or injury	☐	☐
2. allergic/adverse reaction to		
☐ aspirin		
☐ antibiotics (penicillin, sulpha etc…)		
☐ codeine		
☐ local anesthetics, nitrous oxide		
☐ fluoride		
☐ metals (gold, stainless steel, etc…)		
☐ latex		
☐ foods		
☐ any other medications _____		
3. advised against taking any medication	☐	☐
4. heart problems (angina, heart attack, rhythm etc)	☐	☐
5. heart murmur or mitral valve prolapse	☐	☐
6. rheumatic or scarlet fever	☐	☐
7. artificial heart valve or pacemaker	☐	☐
8. artificial joints	☐	☐
9. advised to take antibiotics before dental visit	☐	☐
10. high blood pressure	☐	☐
11. low blood pressure	☐	☐
12. high cholesterol	☐	☐
13. stroke	☐	☐
14. swelling of ankles, feet, or hands	☐	☐
15. anemia or other blood disorder	☐	☐
16. prolonged bleeding due to slight cut	☐	☐
17. asthma	☐	☐
18. bronchitis	☐	☐
19. emphysema	☐	☐
20. tuberculosis	☐	☐
21. shortness of breath on exertion	☐	☐
22. sinus problems	☐	☐
23. kidney disease	☐	☐
24. liver disease/jaundice	☐	☐
25. hepatitis (type_____)	☐	☐
26. thyroid or parathyroid disease	☐	☐
27. hormone deficiency, glandular disorders	☐	☐
28. diabetes (personal or family history)	☐	☐
29. stomach or duodenal ulcer	☐	☐
30. digestive disorders	☐	☐

	YES	NO
31. special diet presently	☐	☐
32. recent weight, appetite or energy level change ...	☐	☐
33. arthritis/rheumatism	☐	☐
34. glaucoma	☐	☐
35. eye glasses/ contact lenses	☐	☐
36. earaches/ear/throat infections frequently	☐	☐
37. hearing difficulties	☐	☐
38. epilepsy or seizures	☐	☐
39. fainting or dizzy spells	☐	☐
40. headaches, severe, frequent	☐	☐
41. head/neck injuries	☐	☐
42. face or jaw surgery	☐	☐
43. HIV/AIDS	☐	☐
44. viral infections, cold sores (herpes)	☐	☐
45. venereal disease	☐	☐
46. any lumps or swelling in the mouth	☐	☐
47. hives, skin rash, hay fever	☐	☐
48. cancer, leukemia, lymphoma	☐	☐
49. tumour, abnormal growth	☐	☐
50. radiation or chemotherapy	☐	☐
51. organ transplant, medical implant	☐	☐
52. emotional problems	☐	☐
53. psychiatric treatment	☐	☐
54. antidepressant medication	☐	☐
55. alcohol/drug dependency	☐	☐
56. eating disorders	☐	☐
57. malignant hyperthermia	☐	☐
58. steroid therapy	☐	☐
59. diet pill therapy	☐	☐
ARE YOU:		
60. presently or in the last year treated for any illness	☐	☐
61. any change in your general health in the last year	☐	☐
62. a heavy smoker(use chewing tobacco)	☐	☐
63. FEMALE - taking birth control pills	☐	☐
64. FEMALE - pregnant (or suspect you are)	☐	☐
65. FEMALE - expected delivery date _____		
66. FEMALE - breast feeding	☐	☐
67. MALE - prostate disorders	☐	☐
68. CHILD - recent measles, mumps, chicken pox	☐	☐
69. CHILD - recent strep throat, tonsillitis	☐	☐

70. Do you currently have, or have had in the past, any disease, condition or problem not listed above?	☐	☐
71. Is there anything else about your health we should be made aware of?	☐	☐
72. Do you wish to speak to the Doctor privately about any problem or medical condition?	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications non-prescription drugs or herbal supplements of any kind

1._____ 2. _____3. _____ 4._____ 5._____

Dentist's Notes_____

_____

_____

_____

RELEASE

I the undersigned, certify that I have provided an accurate and complete personal medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical history. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor(s) or another health care provider may be necessary, and I consent to the release of this information.

Signature_____ Date_____
(Patient or Guardian)

Reviewed by Treating Dentist _____ Date_____