MEDICAL HISTORY

Patient Name_____ Nickname_____ Date of Birth_____
Name of Physician_____
Date of last physical examination _____ Purpose _____
What is your estimate of your general health? Poor ◯ Fair ◯ Good ◉

Please check the appropriate box
Have you ever had the following :

	YES	NO
1. hospitalization for illness, injury,surgery..		
2. allergic reaction to:	--	--
☐aspirin		
☐penicillin		
☐erythromycin.....		
☐codeine		
☐local anesthetic.....		
☐fluoride.....		
☐metals (gold, stainless steel).....		
any other medications_____		
3. heart problems.....		
4. heart murmur.....		
5. high blood pressure.....		
6. low blood pressure.....		
7. a stroke.....		
8. artificial prosthesis (ie heart valve, joints).....		
9. anemia or other blood disorder.....		
10. prolonged bleeding.....		
11. emphysema.....		
12. tuberculosis.....		
13. asthma.....		
14. sinus problems.....		
15. kidney disease.....		
16. liver disease.....		
17. jaundice.....		
18. thyroid or parathyroid disease.....		
19. hormone deficiency.....		
20. high cholesterol.....		

	YES	NO
21. diabetes.....		
22. stomach or duodenal ulcer.....		
23. digestive disorders.....		
24. arthritis.....		
25. glaucoma.....		
26. contact lenses.....		
27. head or neck injuries.....		
28. epilepsy, convulsions (seizures).....		
29. viral infections and cold sores.....		
30. any lumps or swelling in the mouth.....		
31. allergies (hives, skin rash, hay fever.....		
32. venereal disease.....		
33. hepatitis (type____).....		
34. HIV / AIDS.....		
35. tumour, abnormal growth.....		
36. radiation therapy.....		
37. chemotherapy.....		
38. psychiatric treatment.....		
39. antidepressant medication.....		
40. alcohol / drug use.....		
41. tobacco use.....		
42. biphosphonate medication.....		
ARE YOU:	--	--
43. presently being treated for any illness.....		
44. aware of a change in your general health....		
45. FEMALE - taking birth control pills.....		
46. FEMALE - pregnant.....		
47. MALE - Prostate disorders.....		

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

_____

List any medications taken within the last two years_____

_____

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PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY
OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature_____ Date_____

Doctor's Signature_____