Patient Medical History Form

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.

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your health within the past year?	☐	☐
3. Are you under the care of a physician? If yes, please provide:	☐	☐

Physician's Name: _____

4. What was the date of your last physical examination? _____
5. Have you ever been hospitalized for an operation or serious illness? If so, please detail _____

_____

6. Are you taking any medication(s) including non-prescription medication? If so, please list _____

7. Have you ever experienced abnormal bleeding?	☐	☐
8. Do you bruise easily?	☐	☐
9. Have you ever required a blood transfusion?	☐	☐
10. Have you recently had a significant weight loss?	☐	☐
11. Are you taking or have you ever taken Fen-phen or Redux?	☐	☐
12. Do you use Tobacco?	☐	☐
13. Do you use or have you ever used a controlled substance?	☐	☐
14. Are you wearing contact lenses?	☐	☐
15. Do you have any disease, condition or problem not listed above that you think the dentist should know about?	☐	☐

For Women Only

	Yes	No
16. Are you pregnant or think you may be pregnant?	☐	☐
17. Are you nursing?	☐	☐
18. Are you currently taking birth control?	☐	☐

Are you allergic or have had a reaction to:

	Yes	No
Local anesthetics or "freezing"	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin (ASA)	☐	☐
Metals (e.g. nickel, mercury)	☐	☐
Latex/rubber	☐	☐

Other (please specify) _____

Do you have or have you ever had the following:

	Yes	No
Local Anaesthetics (freezing used at the dentist)	☐	☐
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect, Heart Murmur, or had Heart Surgery of any kind	☐	☐
Heart trouble, Heart Attack, or Angina	☐	☐
Chest pain	☐	☐
Pacemaker	☐	☐
High/Low blood pressure	☐	☐
Swelling of feet, ankles, or hands	☐	☐
Hepatitis, Jaundice, or Liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung or breathing problems	☐	☐
Asthma	☐	☐
Hives or Skin Rash	☐	☐
Fainting or Dizzy Spells	☐	☐
Diabetes	☐	☐
Hay Fever	☐	☐

	Yes	No
AIDS or HIV virus	☐	☐
Other sexually transmitted diseases	☐	☐
Thyroid problems	☐	☐
Arthritis or Rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach Ulcer(s)	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Persistent cough or cough that produced blood	☐	☐
Chemotherapy treatment for Cancer or Leukaemia	☐	☐
Epilepsy or Seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsilitis	☐	☐
Mental health issues	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐

Name (please print): _____ Date: _____

Signature: _____