The Downtown Dental Clinic Medical History

Date:_____

Patient Information

First Name:_____Last Name:_____
Birth Date (D/M/Y):_____ ❑Male ❑ Female ☐ other
Cell #: _____ Home #:_____ Work #:_____
Address: _____
Street *Apartment/Unit #*

_____
City *Province* *Postal Code*

Email Address: _____
Health Card #:_____
Name of Pharmacy:_____Phone #:_____
In case of emergency, we should notify:
Name:_____Relationship:_____
Phone #:_____

Family Doctor:_____Phone #:_____
Medical Specialist:_____Phone #:_____

Did anybody refer you to our practice? YES or NO. If you circle yes, please name the person or other office whom referred you to us_____ _____

Health Information

Have you ever had or have any of the following? Please check those that apply.

❑ AIDS	❑ Allergies	❑Anemia	❑Arthritis
❑ Artificial Joints	❑ Asthma	❑ Bleeding Disorders	❑ Blood Disease
❑ Cancer	❑ Cardio-Vascular	❑ Chest Pain	❑ Codeine Allergy
❑ Cortisone treat	❑ Diabetes	❑ Diet Pill Therapy	❑ Dizziness
❑ Drug/Alcohol Dependency	❑ Anticoagulates ❑ Fainting	❑ Anti-Epileptics ❑ Glaucoma	❑ Excessive Bleeding ❑ Growths
❑ Hay Fever	❑ Head Injuries	❑ Heart Attack	❑ Heart Disease
❑ Heart Murmur	❑ Hepatitis	❑ High Blood Pressure	❑ HIV
❑ Jaundice	❑ Kidney Disease		❑ Liver Disease
❑ Lung Disease	❑ Mental Disorders	❑ Nervous Disorders	❑ Oral Contraceptives
❑ Pace Maker	❑ Penicillin Allergy	❑ Prosthetic Heart Valve	
❑ Radiation	❑ Respiratory Issues		❑ Rheumatism
❑ Seizures	❑ Shortness of Breath	❑ Sinus Problems	❑ Steroid Therapy
❑ Stomach Problems	❑ Stroke	❑ Thyroid Disease	❑ TMJ
❑ Tuberculosis	❑ Tumors	❑ Ulcers	❑ Venereal Disease

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last *medical* checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below: a) medications b) latex/rubber products c) other (e.g. hay fever, foods)
❑ YES ❑ NO ❑ NOT SURE/MAYBE

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had any heart or blood pressure problems?
❑YES ❑NO ❑NOT SURE/MAYBE

8. Do you have any conditions or therapies that could affect your immune system, e.g. Leukemia, AIDS, HIV Infection, Radiotherapy, Chemotherapy, Hepatitis, Jaundice or Liver Disease?
❑YES ❑NO ❑NOT SURE/MAYBE

9. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
❑ YES ❑ NO ❑NOT SURE/MAYBE

10. Have you ever been advised by your doctor to take antibiotics before dental treatment?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Are there any conditions or diseases not listed above that you have or have had? If so, what?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Do you smoke or chew tobacco products?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Are you nervous during dental treatment?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Are you currently under the care of a Physician? If yes, please provide their name and contact information. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If any of this information changes or there is any change in my health, I will inform the Dentist and Hygienists.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

WITNESS SIGNATURE:_____DATE_____

DOCTOR SIGNATURE:_____DATE_____