MEDICAL HISTORY FORM

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

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

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

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3. Do you have any allergies? If you answered yes, please list using the categories below.
YES NO NOT SURE/MAYBE

a) Medications
b) Latex/rubber products
c) Other e.g. hayfever, foods

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4. Do you have or have you ever had asthma?
YES NO NOT SURE/MAYBE

Blood Pressure Problems?
YES NO NOT SURE/MAYBE

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5. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
YES NO NOT SURE/MAYBE

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6. Do you have a prosthetic or artificial joint?
YES NO NOT SURE/MAYBE

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

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8. Do you have any conditions or therapies that could affect your immune system?
e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
YES NO NOT SURE/MAYBE

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9. Have you ever had hepatitis, jaundice or liver disease?
YES NO NOT SURE/MAYBE

Bleeding Disorders?
YES NO NOT SURE/MAYBE

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

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11. Are there any disease or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease)
YES NO NOT SURE/MAYBE

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

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

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14. **FOR WOMEN ONLY**: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
YES NO NOT SURE/MAYBE

To the best of my knowledge, the above information is correct.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____