AIRDRIE 8TH STREET DENTAL

Medical History

Patient:_____ **Date:** _____

Address_____**Postal Code:**_____

Phone:_____ **Email:**_____**Birthday:**_____

What method do you prefer being contacted: Phone____ **Email**____ **Text** ____

Are you being treated for any medical condition at the present, or have you been treated in the past year? If so, why?
No ☐

_____

When was your last medical check-up? _____ **Name of Physician (Dr.)**_____

Last Dental Check-up?_____

Has there been any change in your general health in the past year? No ☐
If yes, please explain.

_____

Are you taking any medications, non-prescription drugs, vitamins or herbal supplements of any kind?
If yes, please list them. No ☐

_____

Do you have any allergies? Yes ☐ **No** ☐
If yes, please list using the categories below.

A) **Medications** _____

B) **Latex/rubber products** _____

C) **Other (hay fever/food)** _____

Have you ever had a peculiar or adverse reaction to any medications or injections? Yes ☐ **No** ☐

_____

Do you have or have you ever had asthma? Yes ☐ **No** ☐

Do you have or have you ever had any heart or blood pressure problems? Yes ☐ **No** ☐

_____

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes ☐ **No** ☐

Do you have a prosthetic or artificial joint? Yes ☐ **No** ☐

Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes ☐ **No** ☐

Do you have any conditions or therapies that could affect your immune system? Yes ☐ No ☐
(leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐

Do you have a bleeding problem or bleeding disorder? Yes ☐ No ☐

Have you ever been hospitalized for any illness or operations? Yes ☐ No ☐
If yes, please explain.

_____

Do you have or have you ever had any of the following?

Chest pain, angina	Yes☐ No☐	Steroid therapy	Yes☐ No☐
Prosthetic heart valve	Yes☐ No☐	Diabetes	Yes☐ No☐
Heart attack	Yes☐ No☐	Stomach ulcers	Yes☐ No☐
Pacemaker	Yes☐ No☐	Arthritis	Yes☐ No☐
Stroke	Yes☐ No☐	Seizures (epilepsy)	Yes☐ No☐
Shortness of breath	Yes☐ No☐	Thyroid disease	Yes☐ No☐
Lung disease	Yes☐ No☐	Kidney disease	Yes☐ No☐
Tuberculosis	Yes☐ No☐	Diet pill therapy	Yes☐ No☐
Cancer	Yes☐ No☐	Drug/alcohol dependency	Yes☐ No☐

Are there any conditions or diseases not listed above that you have or have had? No ☐
If so, what are they?

_____

Are there any diseases or medical problems that run in your family? (Diabetes, cancer or heart disease) Yes☐ No☐

_____

Do you smoke or chew tobacco products? Yes☐ No☐

Are you happy with your smile? Yes☐ No☐

Are you interested in Teeth Whitening?_____

For women only:
Are you breast feeding or pregnant? Yes☐ No☐

If pregnant, what is your due date?_____

In case of an emergency, who would you have us contact? Name: _____

Number:_____

Patient Signature_____ Date:_____

Dr. Signature _____