Name:	D.O.B. M D Y	Patient/Parent/Guardian Initial:	Date: M D Y

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist. **YES** **NO**

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____ Physician: _____ Phone: _____
2. Have you been hospitalized in the past two years? _____
3. When was your last visit to a Physician? _____ Last complete physical examination? _____
4. Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs incl. herbal remedies
   1. _____ 2. _____ 3. _____
   4. _____ 5. _____ 6. _____
5. Are you taking Bisphosphonates? If so, for what condition: _____
6. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g. Penicillin, or other antibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: _____
7. Have you ever been advised against taking any specific type of medication? _____
8. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____
9. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____
10. Is there a family history of Diabetes, Cancer or Heart Disease? _____
11. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____
12. Do your ankles, feet or hands swell? _____
13. Has your weight, appetite or energy level changed dramatically recently? _____
14. Do you follow a special diet, or are you on a diet pill therapy? _____
15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____
16. Have you tested HIV positive? _____
17. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____
18. Have you ever had any injury or surgery to your face or jaws? _____
19. Do you wear eyeglasses or contact lenses? _____
20. Do you have any hearing difficulties? _____
21. Do you smoke or use any other forms of tobacco? _____
    Are you wearing the transdermal nicotine patch? _____
22. Are you alcohol and/or drug dependent? _____
    and, Have you received treatment? _____
23. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A B C _____	☐	☐	Scarlet fever → Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	Hodgkins disease	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Cortisone/steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stroke	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	Other _____		
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐	Other _____		
Glandular disorders	☐	☐	Lung disease	☐	☐	Other _____		

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)

Measles _____	☐	☐	Strep throat _____	☐	☐
Mumps _____	☐	☐			
Chicken Pox _____	☐	☐	Tonsillitis _____	☐	☐

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____
25. Is there anything else about your health we should be made aware of? _____
26. Do you wish to speak privately to the Doctor about any problem or medical condition? _____

27. **Women only:** Are you pregnant or suspect you may be? _____ Expected delivery date? _____ Are you breast feeding? _____
    Are you taking any birth control pills? _____ **Women over 50:** Are you aware of your bone mineral density? _____

MEDICAL HISTORY **MEDICAL HISTORY UPDATES**