

PATIENT MEDICAL HISTORY

Date: _____

Name: _____ MSP CareCard No: _____

Date of Birth: Y____/M____/D____ Male Female Height: _____ Weight: _____ BMI: _____

Phone: Res. _____ Cell: _____ Work: _____

Home Address: _____ City/Province: _____

Postal Code: _____ Email: _____ Email contact ok? Yes No

Emergency Contact: _____ Rel.: _____ Tel: _____

If applicable, name of parent or legally authorized representative: _____

Physician's Name: _____

MEDICAL HISTORY QUESTIONNAIRE

Have you ever had a minimal, moderate or deep sedation? Yes No

Any complications or History of familial sedation/anesthetic complications?

If Yes, please describe below Yes No

Anesthetic History/Complications: _____

Are you being treated for any medical condition at present or within the past year? Changes in your general health? If yes, please describe below Yes No

Present Treatment/Changes in Medical Condition: _____

Have you been hospitalized in the last five years? If yes, please describe below Yes No

Hospitalization in past 5 years: _____

Are you taking any prescription or non-prescription drugs, vitamins or herbal supplements? If Yes, describe below Yes No

Do you have any sensitivities or allergies? If yes, please describe below Yes No

Do you have any history of family disease? If yes, please describe below Yes No

When was your last visit to a physician? _____

Date of last complete medical examination? _____

Do you have or have you had? (Please check)

- | | | | | | |
|-------------------------------|--------------------------|------------------------------|--------------------------|-------------------------------|--------------------------|
| AIDS | <input type="checkbox"/> | Glandular disorders..... | <input type="checkbox"/> | Malignant hyperthermia..... | <input type="checkbox"/> |
| Alzheimers | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Medical implant | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Headaches (severe) | <input type="checkbox"/> | Mental/nervous disorder..... | <input type="checkbox"/> |
| Angina pectoris | <input type="checkbox"/> | Head/neck injuries | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> |
| Arthritis/rheumatism | <input type="checkbox"/> | Hearing difficulties | <input type="checkbox"/> | Nosebleeds (frequent) | <input type="checkbox"/> |
| Artificial heart valve | <input type="checkbox"/> | Heart disease or attack | <input type="checkbox"/> | Organ transplant | <input type="checkbox"/> |
| Artificial joints | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | Persistent cough | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Heart pacemaker | <input type="checkbox"/> | Pulmonary edema | <input type="checkbox"/> |
| Balance problems | <input type="checkbox"/> | Heart rhythm disorder | <input type="checkbox"/> | Positive testing for HIV..... | <input type="checkbox"/> |
| Bleed easily | <input type="checkbox"/> | Heart surgery | <input type="checkbox"/> | Psychiatric treatment | <input type="checkbox"/> |
| Blood disorders..... | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | Radiation treatment..... | <input type="checkbox"/> |
| Blood in sputum | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> | Rheumatic/scarlet fever | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Hepatitis C | <input type="checkbox"/> | Sickle cell disease | <input type="checkbox"/> |
| Cerebral palsy | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> |
| Changes in appetite..... | <input type="checkbox"/> | High/low blood pressure . | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> |
| Chest pains | <input type="checkbox"/> | Hodgkin's disease | <input type="checkbox"/> | Sleep Apnea | <input type="checkbox"/> |
| Circulation problems..... | <input type="checkbox"/> | Hyper(hypo) glycemia | <input type="checkbox"/> | Stomach/intestinal problems | <input type="checkbox"/> |
| Congenital heart lesions.... | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Congestive heart failure | <input type="checkbox"/> | Impaired vision | <input type="checkbox"/> | Temperature intolerance..... | <input type="checkbox"/> |
| Cortisone/steroid therapy... | <input type="checkbox"/> | Infective endocarditis..... | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | TMJ..... | <input type="checkbox"/> |
| Earaches (frequent) | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Epilepsy or seizures..... | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | Venereal disease | <input type="checkbox"/> |
| Fainting or dizzy spells..... | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | Weight gain/loss | <input type="checkbox"/> |

- Do you smoke or use other forms of tobacco? Yes No
- Do you have a history of alcohol and/or drug use? Yes No
- Have you received treatment for alcohol or drug use? Yes No
- Do you currently have, or have you had in the past, any disease, condition or problem not listed above? If yes, please describe Yes No
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Is there any problem or medical condition that you wish to discuss in private only? Yes No

- WOMEN ONLY: Are you pregnant or suspect you might be? Yes No
- Anticipated delivery date? _____
- Are you breast feeding? Yes No
- Are you taking any birth control pills? Yes No

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician, pharmacist or insurance provider being contacted if necessary to obtain information that is required for my dental care.

Signature _____ Date _____
 Patient Parent Legally Authorized Representative

Reviewed by Dentist/Physician _____ Date _____