Driftwood Health Services Inc.
10-2401 Cliffe Ave.
Courtenay, BC V9N 2L5
T: 250-338-5381

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:_____ Pharmacy: _____

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

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

_____

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.

ASA Level:

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 _____