Driftwood Dental
Committed to Dental Excellence

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

PATIENT MEDICAL HISTORY

Date: ______________________________

Name: ____ MSP CareCard No: ____________________

Physician's Name: ______________________________ Tel or Address: ________________________

Date of Birth: Y_____/M_____/D_______ ☐ Male ☐ Female Height: _____ Weight: _________ BMI: ________

Phone: Res. _____________________ Work ____________________ Cell ______________________

Home Address: ___________________________________ City/Province: ______________________

Postal Code: ___________ Email: _________________________________ Email contact ok? ☐ Yes ☐ No

Emergency Contact: ___________________________ Rel.: _______________ Phone: _____________

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

MEDICAL HISTORY QUESTIONNAIRE

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

Any complications? If Yes, please describe below ☐ Yes ☐ No

History of familial sedation/anesthetic complications? If Yes, please describe below: ☐ Yes ☐ No

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

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

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

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

When was your last visit to a physician? ____________________________

Last complete medical examination? ______________________________

DESCRIPTIONS (**AS APPLICABLE**)

Sedation Complications: ____

____

Present Treatment/Changes in Medical Condition: ____

____

Hospitalization in past 5 years: ____

____

Family Disease: ____

____

Herbal Supplements/Vitamins/Prescription/Non-Prescription Drugs:

____

____

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

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

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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 ________________