CONFIDENTIAL MEDICAL HISTORY **Patient**_____ **Dr.**_____

Physician's name_____ Phone #_____

1. Are you in good health? Yes ____ No ____ If no, please provide details_____

   _____

2. When was the last time you had a medical examination?_____
3. Are you presently receiving treatment for any illness? If yes, please provide details:_____

   _____

4. Have you ever been hospitalized? If yes, please provide details_____

   _____

5. Do you have any heart or circulatory problems? Yes ____ No ____ Do you have a pacemaker? Yes ____ No ____
6. Have you ever had rheumatic fever? Yes ____ No ____ If yes, when_____
7. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes ____ No ____
8. Do you have allergies? Seasonal/hayfever ____ Food _____ Medication_____

   _____ Other_____

9. Are you presently taking any kind of medication? If yes, please specify:

   Drug _____ Reason _____

   Drug _____ Reason _____

   Drug _____ Reason _____

10. Have you ever had a reaction to any kind of medicine or dental local anaesthetic? If yes, please provide details:

    _____

11. Female patients – Are you pregnant or think you may be pregnant? Yes ___ No ___ Breastfeeding? Yes ___No ___
12. Please indicate below (√) if you **presently have** or **have ever had any** of the following:

❒ AIDS/HIV	❒ Diabetes	❒ Liver disease (Hepatitis/Jaundice)
❒ Alcohol or chemical dependency	❒ Eating disorders	❒ Lung disease/chest pains
❒ Arthritis or Rheumatism	❒ Epilepsy/seizures	❒Mental or nervous disorder
❒ Artificial joints or valves	❒ Fainting/dizzy spells	❒Stomach ulcers
❒ Asthma	❒ High/low blood pressure	❒Stroke
❒ Blood transfusion	❒ Hyper/hypo glycemia	❒Tuberculosis
❒ Cancer/radiotherapy/chemotherapy	❒ Kidney disease	❒Venereal/communicable disease

12. Do you smoke? If yes, how much per day?_____ per week? _____
13. Do you grind or clench your teeth? Yes ___ No ___
14. Do you suffer from headaches____ earaches_____ or neck aches_____?
15. Is there any additional information related to your health that has not been addressed above? _____

    _____

_____ _____ _____ _____

Patient or guardian's signature | Date | Reviewed by | Date

Medical history update:

_____ Date_____By_____

_____ Date_____By_____

_____ Date_____By_____

_____ Date_____By_____