Confidential Medical History Date:_____
Patient:_____

Physician's name:_____ Phone number:_____
Date of your last physical exam:_____ Last visit to a Physician:_____
Are you under the care of a Specialist? □ Yes □ No If so, for what:_____
Do you think you are in good health? □ Yes □ No If no, please explain:_____
_____
Are you presently receiving treatment for any illness: □ Yes □ No If so, please explain: _____
_____
Have you had any surgeries in the last 2 yrs? □ Yes □ No If so, please list them:_____
_____
Have you had any hospitalizations in the last 2 yrs? □ Yes □ No If so, please explain:_____
_____
Have you been advised to take antibiotics prior to dental appointments? □ Yes □ No

Do you have any allergies? □ Seasonal □ Food □ Medications □ Other
If so, please list all known allergies: _____
Have you ever had any reactions to products used in the dental environment? □ Yes □ No
If so, please explain your reaction and the product:_____
Do you smoke or use tobacco products? □ Yes □ No If yes, how much per day:_____

Are you presently taking any medications? □ Yes □ No If so, please list name of medication and use: (Please include non-prescriptions, over the counter and herbal supplements)
Medication_____ Use_____
Medication_____ Use_____
Medication_____ Use_____
Medication_____ Use_____
Medication_____ Use_____
□ I do not know all the names of my medications, please request a list from my pharmacist?

Please use a checkmark to indicate if you presently have or have ever had any of the following:

Cardiovascular System
□ Heart disease, heart attack
□ Angina, chest pain, shortness of breath
□ Pacemaker placed
□ History of infective endocarditis
□ Heart surgery/bypass,artificial valves/stents
□ High blood pressure
□ Low blood pressure
□ Circulation issues/swollen ankles
□ Congenital heart disease
□ History of rheumatic fever

Blood Disorders
□ Cerebralvascular accident (Stroke) or TIA
□ Anemia (low RBC count)
□ Haemophilia (unable to blood clot)
□ AIDS/HIV
□ Sickle cell anemia
□ Leukopenia/neutropenia
□ Have you ever had a blood transfusion
□ Chemotherapy cancer treatment
□ Leukemia

Respiratory Conditions
□ Lung disease
□ Persistant cough or shortness of breath
□ Bronchitis/asthma or hayfever
□ Emphysema or COPD
□ Pneumonia or chronic lung infections
□ Tuberculosis
□ Chronic sinusitis

Digestive System
□ Stomach ulcers/acid reflux
□ Hepatitis A, B or C
□ Liver disease/jaundice
□ Blood in stool or vomiting blood
□ Crohn's disease, cholitis or IBS

Kidney, Urinary and Reproductive, Organs
□ Kidney disease
□ Renal failure
□ Dialysis treatments
□ Syphilis, gonorrhea, herpes, HPV, chlamydia
□ Organ transplant

Bones and Joints
□ Arthritis, inflammation in joints
□ Osteoarthritis/Rheumatoid arthritis
□ Artificial joints (hip, knees or other)
□ Osteoporosis/osteopenia

Neurological/Psychological Conditions
□ Light headed, dizzy, fainting spells
□ Epilepsy/seizures
□ Alzheimer's disease
□ Parkinson's disease
□ Multiple sclerosis
□ Depression/anxiety, psychiatric treatment
□ Drug or alcohol addiction
□ Eating disorders

Endocrine Disorders
□ Diabetes □ Type 1□ Type 2 A1C _____
□ Controlled □ Not controlled
□ Hypoglycemia/Hyperglycemia
□ Frequent thirst, frequent urination
□ Hyperthyroidism
□ Hypothyroidism

Sensory Conditions/Physical Disabilities
□ Blindness, eye disease, glaucoma
□ Loss of hearing, wears a hearing aid
□ Changes in taste
□ Cerebral palsy
□ Uses wheelchair or walker aids
□ Chronic ear aches/headaches

Autoimmune Diseases/Disorders
□ Lupus
□ Sjogren Syndrome
□ Addison Disease
□ Graves Disease
□ Hashimoto Thyroiditis
□ Other:_____
□ Routine prednisone/steroid use
□ Cancer/radiation/chemotherapy

Woman
□ Are you pregnant or nursing?
□ Are you taking birth control medication?
□ Are you taking hormone replacement?

Do you currently have any other disease, condition or diagnosis that has not been listed above?
□ Yes □ No If yes, please specify:_____
Is there anything else about your health we should be made aware of? □ Yes □ No
If yes, please specify:_____

General Release:

I, the undersigned, certify that I have provided and accurate and complete person, medical and dental history to the best of my knowledge. Should there be any changes to my health status or any other information provided, I will advice Something To Smile About. I authorize the release of my information to necessary medical professional, following the Canadian Government Privacy Policy Guidelines.

Patient, Parent or Gaurdian Signature:_____

Whom may I thank for referring you:_____

Medical history reviewed by: _____ Date:_____