CURRENT RIVER DENTAL

Your Centre For Family, Cosmetic & Sedation Dentistry

Print Form

470 Hodder Avenue
Thunder Bay, Ontario P7A 7X5
(807) 683-5222

CONFIDENTIAL MEDICAL HISTORY

For your own safety and to help the dentist plan the best possible treatment options for you, it is important that you complete the medical history. If you are unsure of how to answer a particular question, mark it at the left side and the dentist will go over it with you later.

Patient's Name _____ Height _____ Weight _____ Date of Birth _____

Physician's Name _____

Are you currently in good health? _____

Are you currently seeing a physician for any observations or treatment? _____

Please specify _____

Date of your last physical examination _____

Are you presently taking any prescription or non-prescription drugs, pills or medication? _____

Please specify _____

Are you allergic to any drugs or medications? _____

Please specify _____

Do you have any other allergies (ie. dust, pollen, hayfever, etc.) _____

Please specify _____

Do you have, or have you ever had, any of the following?

- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Heart attack
- ☐ Heart rhythm disorder
- ☐ Chest pain or angina
- ☐ Heart problems of any kind
- ☐ High blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Hepatitis or jaundice
- ☐ Severe headaches
- ☐ Sinus problems
- ☐ Ear aches
- ☐ Hearing problem
- ☐ Psychiatric illness
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Ulcer
- ☐ Frequent indigestion
- ☐ Frequent nausea or vomiting
- ☐ Lung problems
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Frequent or persistent cough
- ☐ Arthritis
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Glaucoma
- ☐ Cancer
- ☐ Malignant hyperthermia
- ☐ Any blood disorder
- ☐ Anemia
- ☐ Abnormal bleeding or bruising
- ☐ Blood transfusion
- ☐ AIDS or HIV

Have you ever become short of breath while at rest? _____

Do you ever get short of breath when lying down? _____

Do you follow a special diet? _____

Do you often find yourself hot or cold when others around you are comfortable? _____

Have you ever had abnormal bleeding after previous extractions, surgery or trauma? _____

Have you ever had a general anaesthetic? _____

Have you, or anyone in your family, ever had an adverse reaction to general anaesthetic? _____

WOMEN ONLY: Are you pregnant? _____ Are you taking oral contraceptives? _____

Have you ever had an operation of any kind? _____

Please specify _____

Do you wear contact lenses? _____

Do you smoke? _____ If yes, how much? _____ For how many years? _____

Are you allergic to, or ever had an unusual reaction to, any of the following?

- ☐ Local anaesthetic (novacaine)
- ☐ Penicillin or other antibiotic
- ☐ Barbituates, sedatives or sleeping pills
- ☐ Sulpha drugs
- ☐ Aspirin
- ☐ Codeine

Others (please specify) _____

During the past 12 months, have you taken any of the following?

- ☐ Medicine for high blood pressure
- ☐ Insulin, orinase or any drug for diabetes
- ☐ Digitalis, inderal or any drugs for heart trouble
- ☐ Cortisone or prednisone (steroids)
- ☐ Anticoagulants
- ☐ Tranquilizers
- ☐ Nitroglycerin
- ☐ Antidepressants

Do you have any disease, condition or problem not listed here that you feel the dentist should know about? _____

Please specify _____

Patient's signature _____ Date _____

MEDICAL HISTORY UPDATE

Has there been any change in the above information since you last filled it out?

Y	N	SIGNATURE	DATE

Y	N	SIGNATURE	DATE