

# PATIENT MEDICAL FORM

Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: (year/Month/Day) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: (circle) Male / Female

Home address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Work / Cell Phone: \_\_\_\_\_

## Medical History: (please check yes or no Box below)

### Yes No

- Have you had a medical checkup within the last year? If not, indicate year of last check up: \_\_\_\_\_
- Have you ever had any general surgery? If so, explain: \_\_\_\_\_
- Have you been treated for any medical conditions within the last year? If so, explain: \_\_\_\_\_

- Have you taken any medicine or drugs within the past month? If so, list: \_\_\_\_\_
- Have you ever been told by a physician (family doctor) that you require antibiotics before dental treatment for a medical condition or any reason? \_\_\_\_\_

- Do you have any conditions or therapies that could affect your immune system, such as Leukemia? \_\_\_\_\_
- Have you ever taken a Bisphosphonate medication such as Actonel (Risedronate), Aredia (Pamidronate), Benefos (Clodronate), Boniva (Ibandronate), Didronel (Etidronate) Fosamax (Alendronate), or Zometa (Zoledronic Acid) for any reason, such as during the treatment of Paget's Disease, Osteoporosis, osteogenesis Imperfecta, Multiple Myeloma, or Metastatic Bone Disease from Breast or Prostrate Cancer?

- Have you taken Cocaine, Ecstasy or Methamphetamine within the last 24 hours?
- Are you allergic to any medicine or drugs such as Local Anaesthetic given by a dentist, Penicillin, Codeine, or Aspirin? If so, list: \_\_\_\_\_

- Are you allergic to latex or rubber?
- Do you have any other allergies? If so, list: \_\_\_\_\_
- Do you smoke or chew tobacco products? If so how often? \_\_\_\_\_
- Women Only** - Are you nursing (breastfeeding) of pregnant? If pregnant, how many months: \_\_\_\_\_

Do you have or have you ever had any of the following: (please check yes or no box below):

### Yes No

- Chest Pain (angina pectoris)
- Heart Attack
- Pacemaker
- Infective Endocarditis
- Congenital Heart Disease
- Heart Transplant
- Prosthetic/ Artificial Joint
- Cancer
- Prosthetic. Artificial Heart Valves
- Radiation Therapy to head/Neck

### Yes No

- Anemia
- High Blood Pressure
- Bleeding Problems/Disorder
- Stroke
- Seizures/Epilepsy
- Thyroid Disease
- Kidney Trouble
- Diabetes

### Yes No

- Arthritis
- Stomach Ulcers
- Sinus Trouble
- Asthma
- Tuberculosis
- Glaucoma
- Steroid Therapy
- Hepatitis
- HIV or AIDS
- Drug/Alcohol dependency

- Do you have any other serious illness? If so, explain: \_\_\_\_\_

Name of your physician (family doctor): \_\_\_\_\_ Phone: \_\_\_\_\_

When was the last time you saw a dentist? \_\_\_\_\_

**The above medical history is complete and accurate. Consent for treatment is hereby given.**

\_\_\_\_\_  
**Signature of Patient / Parent / Guardian**

\_\_\_\_\_  
**Date**