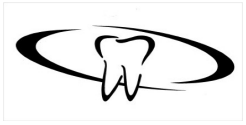

Park Street Dentistry

6 Park Street North,
Peterborough, ON
K9J 3V2
(705) 742-7472

CONFIDENTIAL MEDICAL HISTORY

For your own safety and to help the dentist plan the best possible treatment and diagnoses options for you, it is important that you complete the medical history. If you are unsure of how to answer a particular question, please ask us to explain.

Last Name _____ Date of Birth _____

First Name _____ Title _____

Address _____

Physician's Name _____

Have you been hospitalized? _____ If YES, Explain _____

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

If YES, Please specify _____

Date of your last physical examination _____

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

If YES, Please specify _____

Are you allergic to any drugs or medications? _____

If YES. Please specify _____

Have you been warned against taking any drug or medication? _____

If YES. Please specify _____

Are you allergic to any non medicinal things (ie. nuts, dust, pollen, hayfever, latex etc.) _____

If YES, Please specify _____

WOMEN: Are you pregnant or suspect you might be? _____ If YES, what month are you in? _____

Are you taking birth control pills ? _____

Do you have, or have you ever had, any of the following? Please check all that apply.

☐ Rheumatic fever	☐ Diabetes	☐ Mental or Nervous Disorder	☐ Arthritis
☐ Heart murmur	☐ Thyroid disorder	☐ Epilepsy	☐ Multiple sclerosis
☐ Mitral valve prolapse	☐ Kidney problems	☐ Fainting or dizziness	☐ Muscular dystrophy
☐ Heart attack	☐ Liver problems	☐ Ulcer	☐ Glaucoma
☐ Heart rhythm disorder	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Frequent indigestion	☐ Cancer
☐ Chest pain or angina	☐ Severe headaches	☐ Frequent nausea or vomiting	☐ Malignant hyperthermia
☐ Heart problems of any kind	☐ Sinus problems	☐ Lung problems	☐ Any blood disorder
☐ High blood pressure	☐ Ear aches	☐ Asthma	☐ Anemia
☐ Stroke	☐ Hearing problem	☐ Bronchitis	☐ Abnormal bleeding or bruising
☐ COVID-19		☐ Tuberculosis	☐ Blood transfusion
☐ Joint Replacement (Hip, knee...		☐ Frequent or persistent cough	☐ AIDS or HIV

NOTES: _____

I certify that I have provided an accurate and complete personal and medical history and have not knowingly omitted any information. I understand that the dentist may contact my medical doctor as required and I consent to my physician being contacted. I authorize the dentist to provide dental care for me.

Signature of Patient _____ Date _____