marchdental
"Where Smiles Come Alive"

MEDICAL HISTORY

Patient Name: _____ _____ Date of Birth: _____
Name of Family Physician: _____ PH#: _____
Treating specialist(s) and their specialty: _____ PH#: _____
Most recent physical examination: _____ Purpose: _____
How would you rate your general overall health: ☐Excellent ☐ Good ☐ Fair ☐ Poor

THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL/ORAL HEALTH

	DO YOU HAVE or HAVE YOU EVER HAD:	**Y**	**N**			**Y**	**N**
1	Hospitalization for illness or injury			23	High cholesterol or taking statin drugs		
2	An allergic or bad reaction to any of the following:			24	Diabetes: Type: _____		
	☐ aspirin, ibuprofen, acetaminophen			25	Stomach troubles(i.e.; ulcers)		
	☐ penicillin, sulfa or other antibiotics			26	Digestive or eating disorders:_____		
	☐ sedatives (sleeping pills)			27	Osteoporosis/osteopenia (taking bisphosphonates)		
	☐ codeine or other narcotics			28	Autoimmune disease (i.e.lupus,rheumatoid arthritis)		
	☐ iodine			29	Glaucoma or eye surgery		
	☐ local anesthetic			30	Contact lenses, hearing aid(s)		
	☐ fluoride			31	Head or neck injuries		
	☐ metals (nickel,gold,silver,mercury,_____)			32	Epilepsy, convulsions (seizures), fainting, dizzy spells		
	☐ latex			33	Neurologic disorders (ADD/ADAH, prion disease)		
	☐ foods/flavours/pigments _____			34	Viral infections and cold sores		
	☐ environmental(i.e.; hay fever) _____			35	STI/STD/HPV (i.e.; Syphilis, Gonorrhea)		
	☐ other _____			36	Hepatitis (Type:_____)		
3	Swollen ankles, feet, hands			37	HIV/AIDS		
4	Heart problems, or cardiac stent within last 6 months			38	Tumor(s), abnormal growth(s)		
5	Angina or chest pain			39	Cancer of any type:_____		
6	History of infective endocarditis			40	Radiation therapy		
7	Artificial heart valve, repaired heart defect (PFO)			41	Chemotherapy, immunosuppressive medication: for		
8	Pacemaker or implantable defibrillator				what condition: _____		
9	Orthopedic implant (joint replacement)			42	Emotional difficulties, anxiety, depression		
10	Rheumatic or scarlet fever			43	Psychiatric treatment		
11	High or low blood pressure _____			44	Alcohol/recreational drug use		
12	A stroke (taking blood thinners)			45	Drug or alcohol dependency		
13	Anemia or other blood disorder			46	Steroid therapy		
14	Abnormal bruising or bleeding						
15	Pneumonia, emphysema, shortness of breath						
16	Asthma				**ARE YOU:**		
17	Tuberculosis, measles, chicken pox			47	Presently being treated for any other illness		
18	Sleep apnea, snoring or sinus problems			48	Often feel exhausted or fatigued		
19	Kidney disease, dialysis			49	Experiencing frequent headaches		
20	Liver disease			50	Smoke(d), use(d) smokeless tobacco or chewing tobacco		
21	Jaundice				# of cigarettes per day _____		
22	Thyroid, parathyroid disease, calcium deficiency			51	Currently pregnant or breast feeding		
23	Hormone deficiency			52	Taking birth control medication		

Please describe any current medical treatment, impending surgery or other treatment or condition that is not listed above that may affect your dental treatment. (i.e. Botox, collagen injections): _____

List all medications, supplements (including herbal or dietary) and/or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR HEALTH OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature: _____ Date: _____
Doctor's Signature: _____ Date: _____

FOR DOCTOR'S USE: ASA: _____ BP: _____ Pulse Rate: _____