Medical History

*Required Fields

Medical History

Patient First Name:*

Patient Last Name:*

Patient Birth Date:*

Are you under the care of a physician?

- Yes
- No

Please add your physician's name and contact information here

Have you ever been hospitalized or had a major operation?

- Yes
- No

Please add any details here

Have you ever had a serious head or neck injury?

- Yes
- No

Please add any details here

Are you on a special diet?

- ○ Yes
- ○ No

Please add any details here

Do you use tobacco?

- ○ Yes
- ○ No

Please add any details here

Do you use controlled substances?

- ○ Yes
- ○ No

Please add any details here

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment?

- ○ Yes
- ○ No

Please add any details here

Do you take any blood thinners?

- ○ Yes
- ○ No

Please add any details here

Are you allergic to Penicillin?

- ○ Yes
- ○ No

Please add any details here

Are you pregnant or trying to get pregnant?

- ○ Yes
- ○ No

Are you taking oral contraceptives?

- ○ Yes
- ○ No

Do you have any allergies?

- ☐ Animals
- ☐ Barbiturates or sedatives
- ☐ Codeine or other narcotics
- ☐ Food
- ☐ Iodine
- ☐ Latex
- ☐ Local anaesthetics
- ☐ Metals
- ☐ Penicillin or other antibiotics
- ☐ Seasonal
- ☐ Sulfa drugs
- ☐ Other

Please add any details here

Do you have any medical conditions? We need this information to keep you healthy and safe

Lung or Breathing Conditions

- ☐ Asthma
- ☐ Bronchitis
- ☐ Cystic Fibrosis
- ☐ Tuberculosis

Neurological Conditions

Heart or Circulatory Conditions

- [ ] Autism Spectrum Delays
- [ ] Brain injury
- [ ] Epilepsy
- [ ] Migraines/severe headaches
- [ ] Seizures
- [ ] Developmental Delays
- [ ] Cardiovascular disease
- [ ] Damaged heart valves
- [ ] Heart murmur
- [ ] High blood pressure
- [ ] Infective endocarditis
- [ ] Low blood pressure

Digestive or Dietary Conditions

- [ ] Eating disorder
- [ ] Gastrointestinal disease
- [ ] Malnutrition
- [ ] Special diet

Autoimmune Conditions

- [ ] Celiac disease
- [ ] HIV or AIDS
- [ ] Immune deficiency

General Diseases

- [ ] Anemia
- [ ] Bleeding disorder/Haemophilia
- [ ] Cancer
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Jaundice or Liver disease
- [ ] Renal/Kidney problems
- [ ] Sleep Apnea
- [ ] Other

Please add any details here

Have you ever had any serious illness not listed above?

- ○ Yes
- ○ No

Please add any details here

- [ ] I certify that I have read and understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omissions that I have made in completing these forms.

☐ I agree that the above information is correct to the best of my knowledge

Signature By Patient

Patient's Signature: *

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name: _____ Relationship: _____

Address: _____

Legal Guardian's Signature:

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Submit