Blairmore DENTAL CENTRE

Medical Information

Patient Name: .....

Physician: ..... Physician's Phone: .....

Have you ever been under the care of a physician for a particular condition? ..... **Yes** ☐ **No** ☐

If yes, please describe: .....

Have you been hospitalized in the last 5 years? ..... **Yes** ☐ **No** ☐

If yes, please describe: .....

Are you taking any medications? ..... **Yes** ☐ **No** ☐

List all medications you are currently taking or have taken in the last 2 years. .....

.....

Are you allergic to, or have you had any reactions to any medication or substance before? ..... **Yes** ☐ **No** ☐

If yes, please list .....

Do you have heart disease or any other heart conditions? Please select yes or no.

Heart Disease	**Yes** ☐	**No** ☐	Heart Surgery	**Yes** ☐	**No** ☐	Heart Murmur	**Yes** ☐	**No** ☐
Heart Attack	**Yes** ☐	**No** ☐	Artificial Heart Valve	**Yes** ☐	**No** ☐	Rheumatic Fever	**Yes** ☐	**No** ☐
Chest Pain	**Yes** ☐	**No** ☐	Heart Transplant	**Yes** ☐	**No** ☐	Pacemaker	**Yes** ☐	**No** ☐
Congenital Heart Defect	**Yes** ☐	**No** ☐	Infective Endocarditis	**Yes** ☐	**No** ☐	Mitral Valve Prolapse	**Yes** ☐	**No** ☐
Other Cardiovascular Disease	**Yes** ☐	**No** ☐	If yes to any condition, please explain:					

Do you have high blood pressure? ..... **Yes** ☐ **No** ☐

Do you have low blood pressure? ..... **Yes** ☐ **No** ☐

Have you had a joint replacement procedure? (hip, knee, shoulder) ..... **Yes** ☐ **No** ☐

If yes, when was the surgery? .....

Have you ever required premedication or antibiotics before dental treatment? ..... **Yes** ☐ **No** ☐

Have you ever been told you couldn't give blood? ..... **Yes** ☐ **No** ☐

If yes, what is the reason? .....

Do you have Hepatitis A, B, or C? ..... **Yes** ☐ **No** ☐

Do you have HIV or AIDS? ..... **Yes** ☐ **No** ☐

Have you been exposed to HIV or AIDS? ..... **Yes** ☐ **No** ☐

Have you been exposed to or do you have Tuberculosis (TB)? ..... **Yes** ☐ **No** ☐

Have you ever had cancer/tumors or been treated with radiation/chemotherapy? ..... **Yes** ☐ **No** ☐

If yes, what type of cancer/tumor and when/how was it treated? .....

Do you have diabetes? Type I or Type II? ..... **Yes** ☐ **No** ☐

If yes, how it controlled? .....

Do you smoke or use tobacco? ..... **Yes** ☐ **No** ☐

If yes, how much? .....

Do you use any other drugs or substances? ..... **Yes** ☐ **No** ☐

If yes, what, and how much? .....

Have you taken cortisone or steroids within the last 2 years? ..... **Yes** ☐ **No** ☐

Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Didrocal, Alendronate)? ..... **Yes** ☐ **No** ☐

Are you taking blood thinners? ..... **Yes** ☐ **No** ☐

Have you ever had abnormal bleeding (After tooth extraction, surgery, etc.)? ..... **Yes** ☐ **No** ☐

Blairmore DENTAL CENTRE

Medical Information

For female patients:

Are you pregnant? ..... Yes ☐ No ☐

What month? .....

Are you nursing? ..... Yes ☐ No ☐

Are you taking contraceptives or birth control pills? ..... Yes ☐ No ☐

Do you now have, or ever had any of the following? Please select yes or no.

Stroke	Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Fainting/Dizzy spells	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐	Emphysema/Chronic Cough	Yes ☐	No ☐	Cold Sores	Yes ☐	No ☐
Kidney Trouble	Yes ☐	No ☐	Swollen Ankles	Yes ☐	No ☐	Neurological Disorders	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐	Epilepsy/Seizures	Yes ☐	No ☐
Arthritis or Rheumatism	Yes ☐	No ☐	Anemia	Yes ☐	No ☐	Headaches or Migraines	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐	Psychiatric or Psychological Care	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Latex Sensitivity	Yes ☐	No ☐	Nervous/Anxious	Yes ☐	No ☐
Hemophilia or Blood Disorder _____	Yes ☐	No ☐	Blood Transfusion	Yes ☐	No ☐	Sexually Transmitted Infection/Disease	Yes ☐	No ☐
			If yes, when?			If yes, type:		

Do you have any other health issues not listed above that you think might be important? Any information to add? Please explain.

.....

.....

.....

I understand that the above information is necessary to provide me with dental care in a safe, efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist or his staff to any change in my health or medication.

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information.

Patient Signature _____ Date _____

(Parent or Guardian, if under 18 years of age)