DENTISTRY @ KEMPTVILLE

Medical History

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Patient Name	**Medical Alert** *(Office Use Only)*

Address _____ City _____ Postal Code _____

Phone (home) _____ (cell) _____ Sex M ☐ F ☐ Other _____ Age ____ Birth Date ____ / ____ / ____
day month year

Adult Patient

Occupation _____
Employer _____
Phone (work) _____
Email _____
Marital Status M ☐ S ☐ W ☐ D ☐
Dental Insurance No ☐ Yes ☐ _____

Child Patient

Mother's Name _____
Employer _____ Phone (work) _____
Father's Name _____
Employer _____ Phone (work) _____
Person responsible for account _____
Health Card # _____

How did you find about our office? Friend ☐ Name _____ Phonebook (Yellow Pages) ☐ Newspaper ☐
Flyer ☐ Internet ☐ Website _____ Other ☐ Please Specify _____

1. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐
If yes, for what? _____
Physician's name _____ Phone _____

2. Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

3. Are you taking any medication, drugs or pills now? Yes ☐ No ☐
If yes, please list the name and dosage _____

4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes ☐ No ☐
If yes, please list _____

5. Have you been hospitalized in the past five years? Yes ☐ No ☐

6. Indicate which of the following you have had, or presently have

Heart (Surgery, Disease, Attack)	Yes ☐	No ☐	Latex Sensitivity	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Chest Pain	Yes ☐	No ☐	Stomach Ulcers	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Congenital Heart Disease	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Yellow Jaundice	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	A.I.D.S.	Yes ☐	No ☐
Artificial Heart Valve	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐	H.I.V. Positive	Yes ☐	No ☐
Mitral Valve Prolapse	Yes ☐	No ☐	Chronic Cough	Yes ☐	No ☐	Cold Sores / Fever Blisters	Yes ☐	No ☐
Heart Peacemaker	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Blood Transfusion	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐
Arthritis / Rheumatism	Yes ☐	No ☐	Hay Fever	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐
Cortisone Medicine	Yes ☐	No ☐	Allergies or Hives	Yes ☐	No ☐	Bruise Easily	Yes ☐	No ☐
Swollen Ankles	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐	Neurological Disorders	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Radiation Therapy	Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐
Diet (Special / Restricted)	Yes ☐	No ☐	Chemotherapy	Yes ☐	No ☐	Fainting or Dizzy Spells	Yes ☐	No ☐
Artificial Joints (hip, knee etc.)	Yes ☐	No ☐	Tumors	Yes ☐	No ☐	Nervous / Anxious	Yes ☐	No ☐
Kidney Trouble	Yes ☐	No ☐	Do You Smoke	Yes ☐	No ☐	Psychiatric / Psychological Care	Yes ☐	No ☐

7. Do you have, or have you had any disease, or problem not listed? Yes ☐ No ☐
If yes, please list _____

8. Women Are you: **Pregnant?** Yes ____ Months No ☐ **Nursing?** Yes ☐ No ☐ **Taking Birth Control Pills** Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date ____ / ____ / ____
day month year