MEDICAL HISTORY

MEDIC ALERT	

Date _____
D M Y

	YES	NO
1. Are you presently under the care of a physician? If so, explain: _____	❒	❒
2. Have you had a medical examination in the past year?	❒	❒
3. Do you use any prescription or non-prescription medicine regularly? ..... *** Please supply a complete list of medications from the nursing staff at the residential care facility. ***	❒	❒
4. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies?	❒	❒
5. Have you experienced any unusual reaction to any of the following? (please circle) ..... Local Anaesthesia (freezing), Aspirin, Penicillin, Iodine, Sulfonamide (Sulfa), Barbiturates (sleeping pills), any other medicine? If so, explain: _____	❒	❒

6. Do you have or have you ever had any of the following? (Please check ✓)

❒ Heart murmur or other heart condition	❒ Malignant hyperthermia	❒ AIDS	❒ Herpes	❒ Cortisone/steroid therapy
❒ Stomach/intestinal problems	❒ Drug addiction	❒ Positive testing for HIV virus	❒ Heart attack	
❒ Joint replacement (hip, knee, etc.)	❒ S.T.D.'s		❒ Cold sores	❒ Other
❒ Mental or nervous disorder	❒ Any lung disease	❒ Jaundice	❒ Kidney disease	_____
❒ Hyper (hypo) thyroid	❒ Bleeding gums	❒ Tuberculosis	❒ Sinus trouble	_____
❒ Hyper (hypo) glycemia	❒ Arthritis or rheumatism	❒ Stroke	❒ Osteoporosis	_____
❒ Epilepsy or seizures	❒ Scarlet or rheumatic fever	❒ Cancer	❒ Liver disease	_____
❒ High Blood Pressure	❒ Low Blood Pressure	❒ Hepatitis A/B/C		

	YES	NO
7. Has any member of your family had diabetes? _____	❒	❒
8. Do you bruise easily or bleed abnormally? _____	❒	❒
9. Do you have any blood disorders such as anemia? _____	❒	❒
10. Have you ever had radiation treatment or chemotherapy? _____ If so, explain: _____	❒	❒
11. Have you ever had injury, surgery or x-ray therapy to your face or jaws? _____	❒	❒
12. Do you have frequent headaches? _____	❒	❒
13. Do you have frequent earaches, ear/throat infections or any hearing difficulties? _____	❒	❒
14. Do you smoke? If yes, how many per day? _____	❒	❒
15. Have you ever fainted? _____	❒	❒
16. Do you experience shortness of breath or pain in your chest when walking or climbing stairs? If so, explain: _____	❒	❒
17. Have you had any organ transplants or medical implants? _____	❒	❒
18. Is there anything about yourself that we should be made aware of? _____ If so, explain: _____	❒	❒

GENERAL RELEASE: I, the undersigned understand that the information contained in the medical and dental history in important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I or my dependants have been examined by a dentist in the last 365 days. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Patient (Parent, Guardian*) Signature: _____

If Parent or Guardian*, please print name: _____ Date _____

*Guardian of Child or Guardian of Adult under Guardianship