

**CONFIDENTIAL MEDICAL HISTORY**

DATE: \_\_\_\_\_

Name Mr. Miss Mrs. Ms \_\_\_\_\_ Name of Husband/Wife \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Business Phone(\_\_\_\_\_) \_\_\_\_\_ Cell/Pager #(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (dd/mm/yy) \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Physician \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Referring Dentist \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Do You Have DENTAL INSURANCE? No \_\_\_\_\_ Yes \_\_\_\_\_ If Yes **PLEASE SEE BACK OF FORM** =>=>=>=>=>=>=>

For how long have you been seeing your current regular dentist? \_\_\_\_\_

Name of previous dentist (if applicable) \_\_\_\_\_

How often do you have your teeth cleaned? \_\_\_\_\_ Date of last dental cleaning \_\_\_\_\_

When were you first advised that you needed treatment? \_\_\_\_\_ by whom? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Are you having pain or discomfort at this time? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Do you clench or grind your teeth? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Do any teeth feel loose? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Do your gums bleed when brushing? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Have you ever had gum treatment before? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Are you allergic to any drugs or medication? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Are you taking any medication presently? Please list \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Are you taking any herbal remedies? Please list \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Have you ever had any excessive bleeding ? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Do you smoke? If yes, how many per day? \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT**

Allergies	Diabetes	Hepatitis: A/B/C	Radiation Treatment
Anemia	Dizziness	High Blood Pressure	Respiratory Problems
Angina	Drug Addiction	HIV + (AIDS)	Rheumatic Fever
Arthritis	Emphysema	Hives	Rheumatism
Artificial Joint	Epilepsy	Jaundice	Sickle Cell Disease
Artificial Valve	Excessive Bleeding	Kidney Disease	Sinus Problems
Aspirin Allergy	Excessive Bruising	Liver Disease	Stomach Problems
Asthma	Fainting	Local Anaesth. Allergy	Stroke
Auto-immune Disease	Gastro-Intestinal	Low Blood Pressure	Sulpha Allergy
Barbituates Allergy	Glaucoma	Lupus	Thyroid Disease
Blood Disease	Hard to Freeze	Mental Disorders	TMJ
Cancer	Hay Fever	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Head Injuries	Multiple Sclerosis	Tumors
Codeine Allergy	Heart Disease	Nervous Disorders	Ulcers
Congenital Heart Lesions	Heart Murmur	Pacemaker	Venereal Disease
Contraceptive Use	Heart Surgery	Penicillin Allergy	
Cortisone Medication	Hemophilia	Pre-Medication	

Do you have any disease, condition or problem not listed above? \_\_\_\_\_

WOMEN: Are you pregnant or do you anticipate becoming pregnant in the near future? \_\_\_\_\_

NOTES: \_\_\_\_\_

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.*

⇒ \_\_\_\_\_  
**PATIENT'S SIGNATURE**

⇒ \_\_\_\_\_  
**PERIODONTIST'S SIGNATURE**