

# HARBOUR CENTRE DENTAL

## PATIENT MEDICAL HISTORY

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO	Check if applicable
1. Are you in good health			Do you have or have you ever had the following: Rheumatic heart disease or Rheumatic fever Scarlet fever Heart defect or heart murmur Heart trouble, heart attack or Angina Chest pain Shortness of breath Pacemaker Heart surgery High/low blood pressure Congenital heart problem Swelling of feet, ankles, hands Hepatitis, jaundice or liver disease Stroke Sinus trouble Lung or breathing problems Asthma or hay fever Hives or skin rash Fainting or dizzy spells Diabetes AIDS or HIV infection Thyroid problems Allergies Arthritis or Rheumatism Joint replacement or implant Stomach ulcer Kidney trouble Tuberculosis Persistent cough Cough that produces blood Chemotherapy (cancer, leukaemia) Sexually transmitted disease Epilepsy or seizures Anemia Glaucoma Nervousness Tonsillitis Tumors Mental health care Back problems Chemical dependency Mitral valve prolapse Cortisone treatment Cold sores/fever blisters Hypoglycaemia Eating Disorder
2. Have there been any changes in your health within the past year			
3. Date of your last physical exam _____			
4. Physician's name _____ Address _____ Phone No. _____			
5. Are you now under the care of a physician			
6. Have you ever been hospitalized for any surgical operation or serious illness Please explain _____			
7. Are you taking any medicine(s) including non-prescription medicine If yes, what medicine(s) are you taking _____			
8. Have you had any abnormal bleeding			
9. Do you bruise easily			
10. Have you ever required a blood transfusion			
11. Have you had a recent weight loss			
12. Have you ever taken Fen-Phen or Redux			
13. Do you use tobacco			
14. Do you or have you used controlled substances			
15. Are you wearing contact lenses			
16. Do you have any disease, condition or problem not listed above you think I should know about			
<b>WOMEN ONLY</b> Are you pregnant or think you may be pregnant Are you nursing Are you taking birth control pills  Are you allergic to or have you had reactions to: Local anesthetics like novocaine Penicillin or other antibiotics Sulfa drugs Barbiturates, sedatives or sleeping pills Aspirin Iodine Any metals (e.g. nickel, mercury, etc.) Latex / rubber Other (please list) _____			