MEDICAL INFORMATION

Are you in good health?_____Physicians Name & Contact Number_____

Do you need to take antibiotics before dental appointments?_____Reactions to local novocaine?_____

Illnesses / hospitalizations in last 5 years_____Reactions to general anaesthesia?_____

PLEASE CHECK YES OR NO FOR ALL DISEASES / MEDICAL PROCEDURES / PROCEDURES:

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Mental health problems	☐	☐	Blood transfusion	☐	☐	Contagious diseases
☐	☐	High blood pressure	☐	☐	Problems with immune system *(possible from med. / surg.)*	☐	☐	Blood disorder	☐	☐	Infectious mononucleosis
☐	☐	Low blood pressure	☐	☐	Delay in healing	☐	☐	Bruise easily	☐	☐	Swollen ankles
☐	☐	Mitral valve prolapse	☐	☐	Hay fever / Sinus problems	☐	☐	Eye disease / Glaucoma	☐	☐	Arthritis / Joint disease
☐	☐	Heart murmur	☐	☐	Snoring / Sleep apnea	☐	☐	Jaundice / Liver disease	☐	☐	Prosthetic implant
☐	☐	Chest pain / Angina	☐	☐	Respiratory problems	☐	☐	Hepatitis	☐	☐	Joint replacement
☐	☐	Heart attack(s)	☐	☐	Tuberculosis	☐	☐	Gallbladder trouble	☐	☐	Osteoporosis / Osteopenia
☐	☐	Irregular heart beat	☐	☐	Emphysema	☐	☐	Fainting spells	☐	☐	Osteonecrosis
☐	☐	Cardiac pacemaker	☐	☐	Do you smoke	☐	☐	Convulsions / Epilepsy	☐	☐	Stomach ulcers
☐	☐	Heart Surgery			*if so, # packs a day*_____	☐	☐	Stroke	☐	☐	Tumour or growth
☐	☐	Damaged heart valves	☐	☐	Do you use chewing tobacco	☐	☐	Thyroid trouble	☐	☐	Cancer / Radiation / Chemotherapy
☐	☐	Pneumonia / Bronchitis / Chronic cough	☐	☐	A history of drug abuse	☐	☐	Diabetes	☐	☐	Are you on a diet
☐	☐	Chronic fatigue / Night sweat	☐	☐	A history of alcohol abuse	☐	☐	Low blood sugar	☐	☐	Contract lenses
☐	☐	Trouble climbing 1-2 flights of stairs	☐	☐	Abnormal bleeding	☐	☐	Are you on dialysis			
☐	☐	Anaemia	☐	☐	Bleeding rendency	☐	☐	Kidney trouble			
☐	☐	Asthma				☐	☐	Sexually transmitted diseases			

MEDICATIONS

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Nerve pills	☐	☐	Pain killers (including aspirin)	☐	☐	Muscle relaxers	☐	☐	Stimulants
☐	☐	Diet pills	☐	☐	Tranquilizers	☐	☐	Insulin	☐	☐	Antidepressants
									☐	☐	Blood thinners *(Cournadin, aspirin)*
									☐	☐	Are you taking, or have you every taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, or Aredie with the past 12 years.

Please list any other medications(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

ALLERGIES / REACTIONS

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Pencicillin	☐	☐	Sulfa drugs	☐	☐	Local anaesthetic (numbing med)	☐	☐	Amoxicillin
☐	☐	Sodium pentothal / Valium / other tranq.	☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex
☐	☐	SOV	☐	☐	Eggs /Yolk	☐	☐	Sulfites	☐	☐	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

FOR WOMEN

(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynaecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No
2) Expected delivery date:_____
3) Are you nursing? ☐ Yes ☐ No
4) Are you taking birth control pills: ☐ Yes ☐ No

ANY OTHER MEDICAL CONDITIONS

_____

_____

_____