Patient Medical Information

Gravelbourg Dental Clinic

Tuesday, March 21, 2017

Last Updated:

Title	**First Name**	**Surname**	
Health Card Number		**Email**	
Date of birth	**Occupation**	**Employer**	
Address		**Referred By**	
Canada		**Postal Code**	
Tel Contact			
Emergency Contact		**Emergency Contact Number**	

Are you being treated for any medical condition at the present or or have you been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal suplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?
Yes ☐ No ☐ Not Sure ☐

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? _____

Do you have a prosthetic or artificial joint?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have bleeding problem or bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

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Have you ever been hospitalized for any illness or operations?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes ☐ No ☐ Not Sure ☐

Do you have any of the following? Please Check

☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Sexually Transmitted Infection
☐ Angina	☐ Emphysema	☐ Lung Disease	☐ Shortness of Breath
☐ Anemia	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Arthritis	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Cancer	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Chest Pain	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 1	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 2	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

Have you ever been advised to take antibiotics BEFORE dental treatment?

Women: are you or might you be expecting? If yes which month?

Dentist Dr. Robert Kinniburgh **Tel** 3066484500

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The Information I have given above is true to the best of my knowledge.

Patient Signature **Date** 3/21/2017