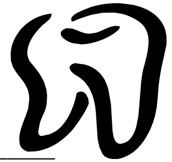
Review of Medical History

Nose Creek Dental Centre



***All replies held in confidence and are to ensure no adverse reactions with anesthetics used in treatment.**

LEGAL - Last Name: ____________________ First Name: ____________________ Preferred Name: ______________________

1. Are you being treated for any medical conditions, and/or has there been any change in your general health since your last visit? If so, what condition? **Yes** **No** **Not Sure/Maybe** ____

2. Do you **currently** have any of the following, please circle: Coughing High Fever Open Sores Vomiting Diarrhea

3. Are you taking or have you taken any **NEW** medications, **Blood Thinners,** non-prescription drugs, herbal supplements or CBD Oil? (e.g.: vitamins, steroids…) **If yes, please list… Yes** **No** **Not Sure/Maybe**

____

Name of Pharmacy where you get your medications ____

4. Have you used cocaine, marijuana or any other drugs in the past year? **Yes** **No** _________________________

5. Do you have any allergies? If yes, please list using the categories below: **Yes** **No** **Not Sure/Maybe**

a) Medication allergies ____

b) latex/rubber product allergies________________________________c) other e.g. hay fever, food others________________________

6. Do you have or have you ever had any Heart or Blood Pressure problems? **Yes** **No** **Not Sure/Maybe**

7. Do you have or have you ever had an artificial heart valve, a history of infective endocarditis, heart transplant, pace maker or a congenital heart defect? **Yes** **No** **Not Sure/Maybe** ____

8. Do you have a prosthetic or artificial joint? **Yes** **No** **Not Sure/Maybe** ____________________________________

9. Have you ever been advised by your doctor to take antibiotics before dental treatment? **Yes** **No** **Not Sure/Maybe**

10. Do you have any conditions or therapies that could affect your immune system please circle: **Yes** **No**

Leukemia AIDS HIV infection Radiotherapy Chemotherapy TB Rheumatoid Arthritis Lupus

11. Have you ever had hepatitis A, B or C, jaundice or liver disease? **Yes** **No** **Not Sure/Maybe** ____________________

12. Do you have bleeding problems or a bleeding disorder? **Yes** **No** **Not Sure/Maybe**

13. Do you have or have you ever had any of the following? **Please circle.**

Chest pain, angina	shortness of breath	steroid therapy	seizures (epilepsy)	Cancer	diet pill therapy
Heart attack	prosthetic heart valve	lung disease	diabetes	kidney disease	drug/alcohol dependency
Stroke	tuberculosis	stomach ulcers	thyroid disease	Arthritis	asthma

14. Are there any conditions not listed above that you have or have had: **Yes No If so, what** ______________________________

15. Are you taking or have you taken Bisphosphonate Therapy (bone density medication)? If so, how long? _______

(E.g. Actonel, Boniva, Fosamax, Skelif, Didronel) **Yes** **No** **Not Sure/Maybe** ______________________

16. Do you smoke, chew tobacco, or vape? **Yes** **No If Yes how much:** ________**for how long** _____________

17. **For Women Only**: Are you pregnant or breast feeding? If pregnant, what is the expected delivery date?

Yes **No** **Not Sure/Maybe** **Due Date:** ___________________________

To the best of my knowledge, the above information is correct

PATIENT/PARENT/GUARDIAN SIGNATURE: ____________________________ DATE: _____________________