**MEDICAL HEALTH HISTORY**

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**ALERTS**

***\*OFFICE USE ONLY\****

*(ALL INFORMATION IS CONFIDENTIAL)*

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you taking any medicine or pills at the present time? □ YES □ NO

If **YES**, please list:

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| --- |
|  |
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|  |

1. Are you allergic to any of the following? □ YES □ NO

If **YES**, please check:

□ ASPIRIN □ PENICILLIN □ CODEINE □ ACRYLLIC □ METAL □ LATEX □ LOCAL ANESTHETICS

□ NSAIDs □ OTHER If **OTHER**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has a doctor advised that you have heart trouble or heart disease? □ YES □ NO
2. Do you suffer from stomach or bladder trouble? □ YES □ NO
3. Has a doctor advised that you have kidney or liver trouble? □ YES □ NO
4. Have you been diagnosed with **HEPATITIS A, B, OR C** □ YES □ NO
5. Have you had abnormal bleeding after a cut or extraction? □ YES □ NO
6. Have you come in contact or been diagnosed with the **AIDS/HIV virus**? □ YES □ NO
7. Have you had any of the following: *(PLEASE CIRCLE)*

|  |  |  |  |
| --- | --- | --- | --- |
| Addison’s Disease | Eating Disorder | High Cholesterol | Stroke |
| Anemia *(Thin Blood)* | Epilepsy | Joint Replacement | Thyroid Disease |
| Asthma | Fractured Jaw | Low Blood Pressure | Tobacco Use / Vaping |
| Cancer | Glaucoma | Osteoporosis | Transplant Surgery |
| Diabetes | High Blood Pressure | Psychiatric Treatment | Tuberculosis |

1. Any other medical condition not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you wear an orthodontic retainer, mouth guard, or bruxism splint? □ YES □ NO

***FOR WOMEN ONLY*:** *(PLEASE CIRCLE)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pregnant ( \_\_\_/mos) | Y | N | Taking Birth Control Pills | | Y | N |
| Nursing | Y | N | On a Fertility Program | | Y | N |
| **To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform West Village Dental Centre of any changes in medical status.** | | | | **Signature** | | | |

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| *\* OFFICE USE ONLY \**  **MEDICAL HEALTH UPDATES** | | | |
| **D** | **M** | **Y** | **NOTES** |
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