

Dentist: \_\_\_\_\_ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

<b>Medical history:</b>					
<b>Name of Physician: Dr.</b>		<b>Specialty, if applicable:</b>			
Office address					
<b>Building name:</b>		<b>Office #:</b>			
<b>House #:</b>		<b>Street:</b>		<b>District:</b>	
<b>City:</b>		<b>Province:</b>			
<b>Postal code:</b>					
<b>Country:</b>					
1. Are you in good health?			0 Yes 0 No		
2. Are you under medical treatment now?			0 Yes 0 No		
If so, what is the condition being treated?					
3. Have you ever had serious illness or surgical operation?			0 Yes 0 No		
If so, when and for what illness or operation?					
4. Have you ever been hospitalized?			0 Yes 0 No		
If so, when and why?					
5. Are you taking any prescription / 0 Non-prescription medication?			0 Yes 0 No		
If so, please specify, include dosage and frequency:					
6. Do you use tobacco products?			0 Yes 0 No		
If so, please specify:					
0 Yes 0 No					
If so, please specify:					
8. Are you allergic to any of the following?			0 None of the list allergies are applicable to the patient		
			0 Local Anesthetic (ex. Lidocaine)		0 Penicillin Antibiotics
			0 Sulfa drugs		0 Asprin
			0 Other:		0 Latex
9. Bleeding time:			min(s)		
10. For women only:		Are you pregnant?		0 Yes 0 No	
		If so, for what term?			
		Are you nursing?		0 Yes 0 No	
		Are you taking birth control pills?		0 Yes 0 No	
		If so, for how long?			
11. Blood type:					
12. Blood pressure:			/		
13. Do you have or have you had any of the following?					
0 None of the list items are applicable to the patient					
0 High Blood Pressure		0 Heart Disease		0 Cancer / Tumors	
0 Low Blood Pressure		0 Heart Murmur		0 Anemia	

0 0 Epilepsy / Convulsions	0 Hepatitis Liver Disease	0 Angina
0 AIDS or HIV Infection	0 Rheumatic Fever	0 Asthma
0 Sexually Transmitted Disease	0 Hay Fever Allergies	0 Emphysema
0 Stomach Troubles / Ulcers	0 Hepatitis / Liver	0 Bleeding Problems
0 Fainting Spells	0 Hepatitis / Jaundice	0 Blood Diseases
0 Rapid Weight Gain / Loss	0 Tuberculosis	0 Head Injuries
0 Radiation Therapy	0 Swollen ankles	0 Arthritis / Rheumatism
0 Joint Replacement / Implant	0 Kidney Disease	0 Other:
0 Heart Surgery	0 Diabetes	
0 Heart Attack	0 Chest pain	
0 Thyroid Problem	0 Stroke	

14. Comment: