

TUDOR GLEN SMILE CLINIC

ST. ALBERT

Medical History Form

Legal Name: _____

Date of Birth: _____

Estimate of your general health?

- Excellent
- Good
- Fair
- Poor

Height: _____ centimeters

Weight: _____ kg

DO YOU HAVE or HAVE YOU EVER HAVE YES / NO
(please specify in writing if necessary)

- | | |
|---|--|
| <p>1. hospitalization for illness, injury, or operation <input type="checkbox"/> / <input type="checkbox"/></p> <p>2. heart problems or cardiovascular problems <input type="checkbox"/> / <input type="checkbox"/></p> <p>3. congenital heart defect, infective endocarditis <input type="checkbox"/> / <input type="checkbox"/></p> <p>4. cardiac stent <input type="checkbox"/> / <input type="checkbox"/></p> <p>5. artificial heart valve, repaired heart defect <input type="checkbox"/> / <input type="checkbox"/></p> <p>6. pacemaker or implantable defibrillator <input type="checkbox"/> / <input type="checkbox"/></p> <p>7. orthopaedic implant (joint replacement) <input type="checkbox"/> / <input type="checkbox"/></p> <p>8. rheumatic fever or scarlet fever <input type="checkbox"/> / <input type="checkbox"/></p> <p>9. high or low blood pressure <input type="checkbox"/> / <input type="checkbox"/></p> <p>10. stroke or transient ischemic attack <input type="checkbox"/> / <input type="checkbox"/></p> <p>11. anaemia or other blood disorder <input type="checkbox"/> / <input type="checkbox"/></p> <p>12. prolonged or abnormal bleeding <input type="checkbox"/> / <input type="checkbox"/></p> <p>13. prolonged or abnormal bruising <input type="checkbox"/> / <input type="checkbox"/></p> <p>14. pneumonia, emphysema, shortness of breath <input type="checkbox"/> / <input type="checkbox"/></p> <p>15. tuberculosis <input type="checkbox"/> / <input type="checkbox"/></p> <p>16. asthma <input type="checkbox"/> / <input type="checkbox"/></p> <p>17. breathing issues (sleep apnea, snoring, sinus) <input type="checkbox"/> / <input type="checkbox"/></p> <p>18. kidney disease <input type="checkbox"/> / <input type="checkbox"/></p> <p>19. liver disease <input type="checkbox"/> / <input type="checkbox"/></p> <p>20. jaundice <input type="checkbox"/> / <input type="checkbox"/></p> <p>21. thyroid/parathyroid disease/calcium deficiency <input type="checkbox"/> / <input type="checkbox"/></p> <p>22. hormone deficiency <input type="checkbox"/> / <input type="checkbox"/></p> <p>23. high cholesterol or taking statin drugs <input type="checkbox"/> / <input type="checkbox"/></p> | <p>24. diabetes (HbA1c = _____)
(blood sugar = _____) <input type="checkbox"/> / <input type="checkbox"/></p> <p>25. stomach or duodenal ulcer <input type="checkbox"/> / <input type="checkbox"/></p> <p>26. digestive or eating disorders (e.g., celiac disease, acid reflux, bulimia, anorexia) <input type="checkbox"/> / <input type="checkbox"/></p> <p>27. osteoporosis/osteopenia (bisphosphonates) <input type="checkbox"/> / <input type="checkbox"/></p> <p>28. arthritis <input type="checkbox"/> / <input type="checkbox"/></p> <p>29. autoimmune disease <input type="checkbox"/> / <input type="checkbox"/></p> <p>30. glaucoma <input type="checkbox"/> / <input type="checkbox"/></p> <p>31. contact lenses <input type="checkbox"/> / <input type="checkbox"/></p> <p>32. head or neck injuries <input type="checkbox"/> / <input type="checkbox"/></p> <p>33. recurrent headaches <input type="checkbox"/> / <input type="checkbox"/></p> <p>34. epilepsy, convulsions, seizures <input type="checkbox"/> / <input type="checkbox"/></p> <p>35. dizziness or fainting <input type="checkbox"/> / <input type="checkbox"/></p> <p>36. neurologic disorders (ADD/ADHD, MS, prion) <input type="checkbox"/> / <input type="checkbox"/></p> <p>37. viral infections, cold sores <input type="checkbox"/> / <input type="checkbox"/></p> <p>38. any lumps or swelling in the mouth <input type="checkbox"/> / <input type="checkbox"/></p> <p>39. hives, skin rash, hay fever <input type="checkbox"/> / <input type="checkbox"/></p> <p>40. STI/STD/HPV <input type="checkbox"/> / <input type="checkbox"/></p> <p>41. hepatitis (Type _____) <input type="checkbox"/> / <input type="checkbox"/></p> <p>42. HIV/AIDS <input type="checkbox"/> / <input type="checkbox"/></p> <p>43. tumour, abnormal growth, cancer <input type="checkbox"/> / <input type="checkbox"/></p> <p>44. radiation therapy <input type="checkbox"/> / <input type="checkbox"/></p> <p>45. chemotherapy, immunosuppressive medication <input type="checkbox"/> / <input type="checkbox"/></p> <p>46. psychiatric treatment <input type="checkbox"/> / <input type="checkbox"/></p> <p>47. treatment for drug/alcohol abuse <input type="checkbox"/> / <input type="checkbox"/></p> <p>48. recreational drug use <input type="checkbox"/> / <input type="checkbox"/></p> <p>49. regular use of tobacco products in any form <input type="checkbox"/> / <input type="checkbox"/></p> <p>50. frequent dry mouth <input type="checkbox"/> / <input type="checkbox"/></p> <p>51. frequent exhaustion or fatigue <input type="checkbox"/> / <input type="checkbox"/></p> <p>52. depression/under stress <input type="checkbox"/> / <input type="checkbox"/></p> <p>53. birth control/contraceptive/hormones <input type="checkbox"/> / <input type="checkbox"/></p> <p>54. currently pregnant <input type="checkbox"/> / <input type="checkbox"/></p> <p>55. any recent changes to your health <input type="checkbox"/> / <input type="checkbox"/></p> |
|---|--|



TUDOR GLEN
S M I L E C L I N I C
S T . A L B E R T

56. aware of any diseases, conditions, or problems
not previously listed (*please specify*) /

Please describe any current medical treatment, impending surgery,
genetic/developmental delay, or other treatment not mentioned:

Please list all medications, dietary supplements, and/or vitamins
taken within the last two years:

Have you ever had an allergic or bad reaction to any of the
following (*please circle*): aspirin, ibuprofen, acetaminophen
(Tylenol), codeine, penicillin, erythromycin, tetracycline, sulpha
drugs, local anaesthetic, fluoride, metals, food colouring, latex,
nuts, fruits, environmental, other (*please specify*):

**PLEASE ADVISE US IN THE FUTURE OF ANY
CHANGE IN YOUR MEDICAL HISTORY OR
ANY MEDICATIONS YOU MAY BE TAKING.**

INFORMED CONSENT AND GENERAL RELEASE: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that responsibility for payment for the dental service provided for me or my dependents and I will assume responsibility for fees associated with these services. I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care

Date: _____

Signature/Guardian Signature: _____