TUDOR GLEN
SMILE CLINIC
ST. ALBERT

Medical History Form

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Legal Name: _____ Date of Birth: MMMM D, YYYY

Estimate of your general health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Height: _____ centimeters
Weight: _____ kg

DO YOU HAVE or HAVE YOU EVER HAVE (*please specify in writing if necessary*)	YES / NO
1. hospitalization for illness, injury, or operation	○/○
2. heart problems or cardiovascular problems	○/○
3. congenital heart defect, infective endocarditis	○/○
4. cardiac stent	○/○
5. artificial heart valve, repaired heart defect	○/○
6. pacemaker or implantable defibrillator	○/○
7. orthopaedic implant (joint replacement)	○/○
8. rheumatic fever or scarlet fever	○/○
9. high or low blood pressure	○/○
10. stroke or transient ischemic attack	○/○
11. anaemia or other blood disorder	○/○
12. prolonged or abnormal bleeding	○/○
13. prolonged or abnormal bruising	○/○
14. pneumonia, emphysema, shortness of breath	○/○
15. tuberculosis	○/○
16. asthma	○/○
17. breathing issues (sleep apnea, snoring, sinus)	○/○
18. kidney disease	○/○
19. liver disease	○/○
20. jaundice	○/○
21. thyroid/parathyroid disease/calcium deficiency	○/○
22. hormone deficiency	○/○
23. high cholesterol or taking statin drugs	○/○
24. diabetes (HbA1c = _____) (blood sugar = _____)	○/○
25. stomach or duodenal ulcer	○/○
26. digestive or eating disorders (e.g., celiac disease, acid reflux, bulimia, anorexia)	○/○
27. osteoporosis/osteopenia (bisphosphonates)	○/○
28. arthritis	○/○
29. autoimmune disease	○/○
30. glaucoma	○/○
31. contact lenses	○/○
32. head or neck injuries	○/○
33. recurrent headaches	○/○
34. epilepsy, convulsions, seizures	○/○
35. dizziness or fainting	○/○
36. neurologic disorders (ADD/ADHD, MS, prion)	○/○
37. viral infections, cold sores	○/○
38. any lumps or swelling in the mouth	○/○
39. hives, skin rash, hay fever	○/○
40. STI/STD/HPV	○/○
41. hepatitis (Type _____)	○/○
42. HIV/AIDS	○/○
43. tumour, abnormal growth, cancer	○/○
44. radiation therapy	○/○
45. chemotherapy, immunosuppressive medication	○/○
46. psychiatric treatment	○/○
47. treatment for drug/alcohol abuse	○/○
48. recreational drug use	○/○
49. regular use of tobacco products in any form	○/○
50. frequent dry mouth	○/○
51. frequent exhaustion or fatigue	○/○
52. depression/under stress	○/○
53. birth control/contraceptive/hormones	○/○
54. currently pregnant	○/○
55. any recent changes to your health	○/○

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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

Signature/Guardian Signature: _____

Date: _____ MMMM D, YYYY

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