CONFIDENTIAL MEDICAL HISTORY

1. Do you see your family doctor regularly? ______ ☐Yes ☐No
2. Are you presently taking pills, drugs or medication? ______ ☐Yes ☐No

   Please specify ______

   ______
3. Have you taken any prolonged medication in the past? ______ ☐Yes ☐No

   Please specify ______

   ______
4. Have you had rheumatic fever? ______ ☐Yes ☐No
5. Have you heart disease or murmer? ______ ☐Yes ☐No
6. Have you had abnormal bleeding? ______ ☐Yes ☐No
7. Have you taken cortisone or steroids? ______ ☐Yes ☐No
8. Have you any allergies? ______ ☐Yes ☐No
9. Have you any allergies to any drugs, medication or latex? ______ ☐Yes ☐No

   i.e. Penicillin Please specify ______
10. Have you ever had radiation therapy? ______ ☐Yes ☐No
11. Do you have or have you had? *(Please circle)*

High Blood Pressure	Anemia	Cancer	Tuberculosis
Low Blood Pressure	Arthritis	Psychiatric Care	Ulcer
Nervous Problems	Epilepsy	Venereal Disease	Fainting Spells
Thyroid Problems	Diabetes	Scarlet Fever	Kidney Trouble
Are You Pregnant?	Liver Trouble	Asthma	
Heart Trouble	Blood Disorders	Sinus Problems	
Chest Pain	Herpes	Stroke	

12. Have you had exposure to the AIDS/HIV virus or Hepatitus virus? ☐Yes ☐No
13. Are you currently in good health? ______ ☐Yes ☐No
14. Is there anything else you think you should tell me? ______ ☐Yes ☐No

    Please specify ______
15. How did you hear about our clinic?

______

PATIENT CERTIFICATION & APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Signature of Patient ______ **Date** ______

(Parent or Guardian)