DATE: / / (M D Y)

PATIENT IS AN: ADULT CHILD ADULT UNDER GUARDIANSHIP NAME OF GUARDIAN _____

Name:_____ Nickname: _____ Dr. Mrs. Ms. Mr.

Home Address:_____
(street) (city) (prov.) (postal code)

Home Phone: __ (_____)_____ Cellular Phone: __ (_____)_____ Fax#: __ (_____)_____

Date of Birth: / / (M D Y) Age:_____ Sex: _____ Marital Status: _____

Driver's License #: _____

Family Physician: _____ Phone: __ (_____)_____

Medical Specialist (if presently under care): _____ Phone: __ (_____)_____

OCCUPATION:_____

Employed By: _____ Phone: __ (_____)_____ Ext. _____

Spouse Employed By: _____ Phone: __ (_____)_____ Ext. _____

DENTAL INSURANCE: Yes No Group Policy #:_____ Certif. #:_____

Primary Insurance Co. Name: _____

Secondary Ins. Co. Name: _____

Group Policy #:_____ Certif. #:_____

PERSON RESPONSIBLE FOR ACCOUNT: Self Other Name: _____

Address: _____ Driver's License #: _____

Home Phone: __ (_____)_____ Business Phone: __ (_____)_____Ext. _____S.I.N.: _____

IN CASE OF EMERGENCY Please Notify: _____ Relationship: _____

Home Phone: __ (_____)_____ Business Phone: __ (_____)_____ Ext. _____

Is any other member of your family or relative a patient at our office? _____

REASON FOR TODAY'S VISIT: Examination Emergency Other _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY PLEASE CHECK YES OR NO. IF NOT SURE, CHECK NS.	NO	NS	YES
Are you presently under a Doctor's care? Why?			
Have you been under Doctor's care in the past two years? Why?			
Have you taken any medication, pills or drugs in the past two years?			
Are you presently taking medication, pills or drugs? If YES, please list them:			
Have you ever had Tonsillitis?			
Have you been hospitalised in the past two years? (If yes, why?)			
Have you ever had any type of surgery? What & When?			
When was your last complete physical examination?			
When walking, do you ever have to stop because of pain in your chest or shortness of breath?			
Are you on a prescription diet?			
Have you ever been diagnosed as having a tumor or cancer?			
Have you ever taken cortisone/steroid medication?			
Do you experience problems with healing?			
Do you wish to speak privately with the Doctor about any problems?			
Do you smoke? (If yes, how much?)			
Are you currently in good health?			
Do you bruise easily or bleed excessively?			
Have you ever been warned about anaesthetic risks?			
Do you drink alcohol? (If yes, how much?)			

SHADED AREAS - OFFICE USE ONLY

MEDICAL ALERT	CONDITION	PRE MEDICATION	ALLERGIES	ANAEST

ALLERGIES	Please check off any medications you are allergic to or you have reacted adversely to:				
▫ Ibuprofen (Advil)	▫ Nembutal	▫ Demerol	▫ Ampicillin	▫ Rovamycin	▫ Local Anaesthetic (Freezing)
▫ Aspirin	▫ Seconal	▫ Percodan	▫ Erythromycin	▫ Cedhalexin	▫ Nitrous Oxide
▫ Tylenol	▫ Naproxen	▫ Darvon	▫ Clindamycin	▫ Sulpha Drugs	▫ Amoxicillin
▫ Tylenol #2, #3, # 4	▫ Toradol	▫ Penicillin	▫ Scopolamine	▫ Metal	▫ Chlorhexidene (Peridex)
▫ 222, 282, 292	▫ Codeine	▫ Valium	▫ Tetracycline	▫ Latex	▫ Bandage
▫ **Food Allergies, please list:**					
Please list any other medication or substances which you know you are allergic to:					

MEDICAL CONDITIONS	Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)										
	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips			
Transdermal Nicotine Patches				Ulcers				Diabetes or Hypoglycemia			
High Blood Pressure/Hypertension				Asthma				Arthritis/Rheumatism			
Low Blood Pressure				Hay Fever				Epilepsy or Seizures			
Heart Failure				Sinus Trouble				Glandular Disorders			
Congenital Heart Lesion				Emphysema				Psychiatric Care			
Artificial Heart Valve				Frequent Cough				Mental/Nervous Disorders			
Heart Pacemaker				Lung Disease				AIDS (HIV Positive)			
Heart Surgery				Bronchitis				Venereal disease			
Heart Murmur				Tuberculosis				Herpes			
Mitral Valve Prolapse				Liver Disease				Cold sores			
Chest Pain				Hepatitis A (infec.)				Fever blisters			
Angina Pectoris				Hepatitis B (serum)				Blood Disorders			
Shortness of Breath				Hepatitis C				Circulation Problems			
Stroke				Yellow Jaundice				Sickle Cell Anemia			
Fainting or Dizziness				Thyroid Disease				Hemophilia			
Anemia				Glaucoma				Cancer			
Cardiac Arrest/Heart Attack				Pain in Jaw Joints				Chemotherapy/Radiation			
Swelling of Feet/Ankles/Hands				Head/Neck Injuries				X-Ray/Cobalt Treatment			
Drug or Alcohol Addiction				If Yes, have you received treatment?				Where?			
Is there anything else we have not mentioned that you think we should know regarding your medical history?											

WOMEN ONLY						
	Are you pregnant?	Yes	No	Are you taking Fertility drugs?	Yes	No
	Are you nursing?	Yes	No	Are you taking Birth Control Pills?	Yes	No

Follow-up information to above questions: