Calgary Dental House Medical History

Name:	Family Dr:	Date:

Yes	No	
		Are you being treated for any medical condition at present or within the past 2 years? If yes, please explain.
		Have you been hospitalized within the past 2 years? If so, why?
		Have you had a complete medical examination within the past year? If so, when?
		Have you recently, or are you presently taking Prescription or Non-Prescription drugs? If yes, please list, or provide the receptionist with a medications print out from your Pharmacist.
		Have you ever reacted adversely to any of the following: Antibiotics, Penicillin, Sulfonamide, other antibiotics, Aspirin, Barbiturates (sleeping pills), Codeine, Darvon, Local Anesthetic (freezing), Nitrous Oxide, or any other medicine? Please explain.
		Have you ever been advised against taking any specific type of medicine? If yes, please explain.
		Do you have any of the following: Asthma, Hay Fever, Food Allergies, Metal or Latex allergies, Skin Rashes, Hives, or any other allergic conditions?
		Do you smoke or use any other form of tobacco? If yes, how much?
		Are you wearing the transdermal nicotine patch?
		Are you alcohol and / or drug dependent?
		Have you ever received treatment for alcohol and / or drug dependency?

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Name:	Family Dr:	Date:

Yes	No	
		Indicate which of the following you presently have or ever had: A.I.D.S, Abnormal Pap Smear, Anemia, Arthritis / Rheumatism, Artificial Joints, Blood Disorders, Bronchitis, Cancer, Circulation Problems, Congenital Heart Problems, Cortisone / Steroid treatment, Diabetes, Emphysema, Epilepsy / Seizures, Fainting / Dizzy Spells, Glandular Disorders, Glaucoma, Head / Neck Injuries, Heart Attack or Disease, Heart Pacemaker, Heart Rhythm Disorder, Heart Surgery, Hepatitis A, B or C, Herpes, High / Low Blood Pressure, Hodgkin's Disease, Hyperglycemia / Hypoglycemia, Hypertension, HPV, Jaundice, Kidney Disease, Liver Disease, Lung Disease, Malignant Hyperthermia, Mitral Valve Prolapse, Multiple Sclerosis, Organ Transplant / Implant, Parkinson's , Psychiatric Treatment, Radiation Treatment, Rheumatic / Scarlet Fever, Sickle Cell Disease, Sinus Trouble, Stomach / Intestine Problems, Stroke, Thyroid Disease, Tuberculosis, Ulcers, Venereal Disease, Other?
		WOMEN ONLY: Are you pregnant or suspect you may be? If yes, what month?
		WOMEN ONLY: Are you taking Birth Control Pills? If yes, what kind?
		Do you currently have, or have you ever had in the past, any disease, condition or problem not listed above?
		Is there anything else about your health that we should be made aware of?
		Do you wish to speak to the dentist privately about any problem or medical condition?