CARLETON SQUARE DENTAL CENTRE

MEDICAL HISTORY UPDATE

Family Doctor: _______________________ Doctors Phone number: ______________________

Do you use any medicine now? If so please list

____

Are you presently under the care of a physician? No ___ Yes ___If yes, please explain:

____

Have you had a medical exam in the past year? No ___ Yes ___

Have you ever been hospitalized or have had surgery? No ___ Yes ___ if yes please explain:

____

Have you ever had any of the following? (please circle)

Hepatitis diabetes high blood pressure low blood pressure lung disease heart attack heart murmur heart disease stroke epilepsy cancer arthritis kidney disease mental or nervous disorders rheumatic fever stomach problems allergies AIDS HIV+

Do you have any condition not listed above you think the dentist should know about?

____

Have you ever experienced any unusual reactions to any of the following?

Aspirin Penicillin Iodine sulfonamide (sulfa) Barbiturates (sleeping pills) Local anesthesia Latex

None of the above other: ______________________________

Do you bruise or bleed abnormally? No ___ Yes ___

Do you have any prosthetic implants or joints? (ie: knee, hip) No ___ Yes ___

Women only: Are you pregnant? No ___ Yes ___

Patient Name: __________________________________

Patient Signature: ________________________________ Date month ____ day ____ Year ____