**Name**: _____ **Date of Birth**:_____

**Medical History:**

**Name of Family Physician: _____**

**Family Physician address: _____**

**Family Physician phone: _____**

**Name of Specialist(s): _____**

**Specialist(s) Phone Number(s):_____**

**Pharmacy Name and phone Number: _____**

**Has there been any change in your general health in the past year? YES__ or NO__**

**If yes, Please explain_____**

**Have you been hospitalized in the past 2 years? YES__ or NO__**

**If yes, Please explain_____**

**For Women only: are you pregnant or planning to become pregnant YES or NO __**

**Are you breast-feeding YES__ or NO __**

**Are you taking any medications such as:**

1) **Medication:_____**
2) **Medical marijuana_____**
3) **Herbal supplements/Vitamins of any kind_____**
4) **A copy of medication list has been given to receptionist YES__ or NO__**

**Are you allergic or have had bad reactions to or have any unusual reactions to (please check)**

**__ Amphetamines __Epinephrine (adrenalin) __Aspirin __ Penicillin __Tylenol**

**__Sulfa Drugs __Codeine __Barbituates (sleeping pills) __Motrin/Ibuprophen/Advil**

**__Medications not listed_____**

**__Metal (specify) __Latex/Rubber __Enviromental Allergies**

**Have you ever had a bad reaction to any local anaesthetic (freezing)**

**__YES or NO__**

**If yes, Please explain_____**

**(OVER)**

**Do you now, or have you ever had the following (please check)**

**__Heart Disease**
**__Heart Attack, Year____**
**__Pace maker, Year_____**
**__Heart Valve replacement,**
**__Heart Murmur**
**__ Mitral Valve Prolapse**
**__Angina/Chest Pain**
**__Stroke, Year ____**
**__High Blood Pressure**
**__Joint replacement (hip/Knee),**
**__eating disorders**
**__immune systems disease**
**__Fainting Spells**
**__Thyroid disease**
**__Injury or surgery on your face or jaw, Year_____**

**__Hepatitis __A __B __C**
**__Emphysema/COPD**
**__Asthma**
**__Shortness of breath**
**__Tuberculosis/lung disease**
**__Malignant hyperthermia**
**__rheumatic fever**
**__Hay fever/allergies**
**__Steroid therapy**
**__Cancer/leukemia**
**__HIV/AIDS,**
**__Anemia**
**__Head/back problems**

**__Stomach ulcers**
**__gastrointestinal disease**
**__Liver disease**
**__Kidney disease**
**__Bleeding/clotting Problems**
**__Arthritis**
**__Neuralgia**
**__Glaucoma**
**__Anxiety/Panic Attacks**
**__Seizures**
**__Radiation Treatment**
**__Major Surgery**
**__Drug/alcohol dependency**

**Do you smoke or chew tobacco products __ YES or NO__**

**If yes, how many per day___ for how many years___**

**Do you use an E-Cigarette __YES or NO __**

**Do you tend to gag when having dental treatment __ YES or NO__**

**Are you nervous during dental treatment __YES or NO__**

**Emergency Contact Name: _____**

**Emergency Contact Number: _____**

## CONSENT:

**This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic, sedation as indicated and I will assume full responsibility for fees associated with those procedures.**

**To the best of my knowledge, the above information is correct:**

**Patient/Guardian_____ Date:_____**