MEDICAL HISTORY

West Kootenay Community TEETH Clinic
A Successful Life Begins with a Healthy Smile

Patient's Name _____ (FIRST) _____ (LAST) _____ (NICKNAME/PRONOUNCIATION)

If a Child: Name of Guardian(s) _____

Date of Birth (Year/Month/Day) _____ Gender _____

Partner's Name _____

How is your general health? **EXCELLENT** **GOOD** **FAIR** **POOR**

Family Doctor Name _____ Phone _____ Email _____

Date of last medical exam _____

Have your ever consulted a Medical Specialist? If yes, please list their name and phone number.

Orthopedic Surgeon **Name** _____ **Phone** _____

Oncologist **Name** _____ **Phone** _____

Cardiologist **Name** _____ **Phone** _____

Other **Name** _____ **Phone** _____

Please (X) all that apply:

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
Heart Problems	( )	( )	Kidney Disease	( )	( )	Prolonged Bleeding	( )	( )
Repaired Heart Defect	( )	( )	Ulcers	( )	( )	Joint Replacement	( )	( )
Cardiac Stent	( )	( )	Hepatitis A B C	( )	( )	Cancer	( )	( )
High/Low Blood Pressure	( )	( )	Cold Sores	( )	( )	Radiation Treatment	( )	( )
Asthma/Difficulty Breathing	( )	( )	Artificial Heart Valve	( )	( )	Epilepsy/Convulsions	( )	( )
Diabetes Controlled/Uncontrolled	( )	( )	Pacemaker	( )	( )	GERD/Acid Reflux	( )	( )
Chemotherapy	( )	( )	Stroke	( )	( )	Eating Disorder	( )	( )

Please list all current medications, supplements, and vitamins, or attach a Pharmacy List

Drug _____ **Purpose** _____ **Drug** _____ **Purpose** _____

Drug _____ **Purpose** _____ **Drug** _____ **Purpose** _____

Do you have any allergies or have you ever had any unusual reactions to the following?

Penicillin ( ) Codeine ( ) Local Anesthetic ( ) Sulfa Drugs ( ) Latex ( ) Metals ( ) Specific Antibiotics ( )

Other (Please Specify) _____

Have you ever been advised to take antibiotics prior to dental treatment?

No ( ) Yes ( ) Describe _____

Have you had any surgery in the last 2 years? No ( ) Yes ( ) Describe _____

Do you take bloods thinners or a baby (81mg) aspirin daily No ( ) Yes ( )

Are you currently or have you ever taken any Bisphosphonate Drugs No ( ) Yes ( )

Do you use any of the following? ☐ Cigarettes/Vapes ☐ Cigars ☐ Marijuana

If YES, how often? _____ For how long? _____

Are there any serious medical conditions not mentioned? Describe _____

I certify that the above information is true and complete to the best of my knowledge.

_____ (PATIENT OR GUARDIAN SIGNATURE) _____ (DATE)