

Title	First Name	Surname	
Health Card Number			
Date of birth	Occupation		
Address		Postal Code	
Tel Contact	Home Phone#	Work Phone#	Mobile Phone#
Emergency Contact	Emergency Contact Number		

Are you being treated for any medical condition at the present or or have you been treated within the last year?
Yes No Not Sure

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year?
Yes No Not Sure

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes No Not Sure

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes No Not Sure

Medications _____
Latex/Rubber Products _____
Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections?
Yes No Not Sure

If yes, please explain _____

Do you have or have you ever had asthma?
Yes No Not Sure

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?
Yes No Not Sure

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis),
a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes No Not Sure

Have you ever had hepatitis, jaundice or liver disease?
Yes No Not Sure

Which type of hepatitis? _____

Do you have a prosthetic or artificial joint?
Yes No Not Sure

If yes, please explain _____

Do you have bleeding problem or bleeding disorder?
Yes No Not Sure

If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

Yes No Not Sure

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes No Not Sure

Do you have any of the following? Please Check

<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Steroid Therapy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Head/Neck Injury	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thrush
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis Medications (e.g. Fosamax, Actonel)	<input type="checkbox"/> TMJ Disorder
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Parkinsons Disease	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Hodgkins Disease	<input type="checkbox"/> Radiation/Chemotherapy	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Drug / Alcohol Dependency	<input type="checkbox"/> Hypo/Hyperglycemia	<input type="checkbox"/> Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes No Not Sure

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes No Not Sure

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes No Not Sure

Are you nervous during dental treatment?

Yes No Not Sure

Any dental concerns?

Are you pregnant?

If so, how many months?

Are you taking birth control?

Dentist **Tel**

Address

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The Information I have given above is true to the best of my knowledge.

Patient Signature **Date**