MEDICAL HISTORY

BPR (office use only)**: _____/_____**

1. Health Card number (for prescriptions): _____
2. Medical Doctor: _____Phone number: _____
3. Medical Specialist: _____Phone number: _____
4. Are you being treated for any medical condition at the present or have you been treated in the past year? Yes ☐ or No ☐? If Yes, why?
5. When was your last medical checkup? _____
6. Has there been any changes in your general health in the past year? Yes ☐ or No☐? If yes, please explain.

   _____
7. Do you have any Allergies? Yes ☐ or No ☐? If yes, please list below.

   _____
8. Are you taking Any medication, non-prescription drugs, or herbal supplements of any kind? Yes ☐ or No☐? If yes, please list below or provide us with a printed list of your medications.
   Pharmacy: _____ Phone number:_____

Medication	What for?	Dose	Frequency

9. Have you ever had a peculiar reaction to any medicine or injection? Yes ☐ or No ☐? If yes please explain.

   _____
10.

☐ A.I.D.S.	☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Psychiatric/Psychological Care
☐ Allergies or Hives	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Therapy
☐ Arthritis / Rheumatism	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Diet (Special / Restricted)	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Joints (hip, knee etc.)	☐ You Smoke	☐ H.I.V. Positive	☐ Sinus Trouble
☐ Asthma	☐ Emphysema	☐ Jaundice	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Epilepsy or Seizures	☐ Kidney Trouble	☐ Stroke
☐ Bruise Easily	☐ Fainting or Dizzy Spells	☐ Latex Sensitivity	☐ Swollen Ankles
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Tuberculosis
☐ Chest Pain	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tumors
☐ Chronic Cough	☐ Heart (Surgery, Disease, Attack)	☐ Nervous / Anxious	☐ Thyroid Problems
☐ Cold Sores / Fever Blisters	☐ Heart Murmur	☐ Neurological Disorders	☐ Venereal Disease

11. Are there any conditions or disease not listed above that you have or had? Yes ☐ or ☐ No? If yes please explain: _____
12. Are there any diseases or medical conditions that run in your family? (e.g. cancer, diabetes, heart disease …) Yes ☐ or No ☐? If yes, please list: _____
13. Do you smoke / Vape Yes ☐ or No ☐? tabaco ☐ Cannabis☐? If yes How Often? _____
14. Are you Pregnant or breast feeding Yes ☐ or ☐ No? If pregnant, what is the delivery date? _____
15. Is there anything else you would like to mention to the dentist that has not been covered on this form?

    _____

To the best of my knowledge, the information is correct.

Print name: _____

Patient / Parent / Guardian signature: _____ Date: DD_____/MM_____/YY_____

Dentist signature: _____ Date: DD_____/MM_____/YY_____