

CAMBIE MARINE GATEWAY DENTAL

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 ___