HEALTH HISTORY **Patient's Name** _____

1. Have you been hospitalized during the past two years? ..... ❑ Yes ❑ No
2. Have you been under the care of a medical doctor during the past two years? ..... ❑ Yes ❑ No

Physician's Name _____

Address _____

_____ Tel. # _____

3. Have you taken any medicine or drugs during the past two years? ..... ❑ Yes ❑ No
   Are you taking any drugs, medications or pills presently? ..... ❑ Yes ❑ No

If yes, please list _____

4. **Are you allergic or have you ever reacted adversely to any of the following?**

Aspirin	Fluoride	Latex/Rubber
Codeine	Percocet	Erythromycin
Nitrous oxide	Penicillin	Tetracycline
Local anaesthetic	Other antibiotics	

5. Are you aware of being allergic to any other medications or substance? ..... ❑ Yes ❑ No

If yes, please list _____

6. **Circle any of the following which you have had or presently have:**

Angina Pectoris	Epilepsy or Seizures	Neck or Back Problems
Arthritis	Fainting or Dizzy Spells	Osteoarthritis Medication
Artificial Heart Valve	Glaucoma	Pain in Jaw Joints
Artificial Joints (Hip, Knee)	Heart Failure	Psychiatric Therapy
Anemia	Heart Disease or Attack	Rheumatic Fever
Asthma	High Blood Pressure	Rheumatism
Allergies or Hives	Heart Murmur	Scarlet Fever
Bleeding Disorders	Heart Pacemaker	Stroke
Blood Transfusion	Heart Surgery	Sinus Trouble
Bruise Easily	Hay Fever	Tuberculosis (TB)
Congenital Heart Lesions	Hemophilia	Thyroid Disease
Cough	Hypoglycemia	Ulcers
Chemotherapy (Cancer, Leukemia)	Hearing Problems	Venereal Disease (Syphilis, Gonorrhea)
Cold Sores	Kidney Trouble	Visual Problems
Diabetes	Liver Disease	Yellow Jaundice
Drug Addiction	Malignant Hyperthermia	X-ray or Cobalt Treatment
Difficulty with fine motor skills	Mitral Valve Prolapse	Other (Specify)
Emphysema	Nervousness	

7. Have you ever tested positive for HIV, Hepatitis A, Hepatitis B or Hepatitis C (Circle)..... ❑ Yes ❑ No
8. Are you on a special diet? ..... ❑ Yes ❑ No
9. List any surgery or operations which you have had (eg. tonsils, gall bladder) _____

_____

10. Do you have any disability that requires extra attention in our office? ..... ❑ Yes ❑ No
11. Do you agree to the use of diagnostic xrays? ..... ❑ Yes ❑ No
12. Do you agree to fluoride treatments for your child? ..... ❑ Yes ❑ No
13. Do you smoke or chew tobacco products? ..... ❑ Yes ❑ No
14. Are you pregnant? Yes No If yes, what month? _____

I CERTIFY THE ABOVE INFORMATION IS TRUE

I consent to a full dental examination including xrays and other tests as necessary. "The undersigned hereby consents to the collection and use of personal information about me in accordance with The Personal Information Protection and Electronics Documents Act."

_____ _____ _____

Patient's Signature (Parent if under 16) Date Dentist's Initial

MEDICAL UPDATE FORM

The purpose of this form is to ensure that the staff of the Kawartha Dental Clinic is aware of your present health condition. Please notify your dentist, dental hygienist or dental assistant of any new changes in your health, then please sign below.

DATE OF APPOINTMENT	CHANGES IN HEALTH? (IF ANY)	SIGNATURE