ALERTS

OFFICE USE ONLY

MEDICAL HEALTH HISTORY

(ALL INFORMATION IS CONFIDENTIAL)

DATE _____ PATIENT'S NAME _____

1. Name of Physician: _____ Clinic: _____
2. Are you taking any medicine or pills at the present time? ☐ YES ☐ NO
   If **YES**, please list:

   _____

   _____

   _____
3. Are you allergic to any of the following? ☐ YES ☐ NO
   If **YES**, please check:
   ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLLIC ☐ METAL ☐ LATEX ☐ LOCAL ANESTHETICS
   ☐ NSAIDs ☐ OTHER If **OTHER**, please explain: _____
4. Has a doctor advised that you have heart trouble or heart disease? ☐ YES ☐ NO
5. Do you suffer from stomach or bladder trouble? ☐ YES ☐ NO
6. Has a doctor advised that you have kidney or liver trouble? ☐ YES ☐ NO
7. Have you been diagnosed with **HEPATITIS A, B, OR C** ☐ YES ☐ NO
8. Have you had abnormal bleeding after a cut or extraction? ☐ YES ☐ NO
9. Have you come in contact or been diagnosed with the **AIDS/HIV virus**? ☐ YES ☐ NO
10. Have you had any of the following: *(PLEASE CIRCLE)*

Addison's Disease	Eating Disorder	High Cholesterol	Stroke
Anemia *(Thin Blood)*	Epilepsy	Joint Replacement	Thyroid Disease
Asthma	Fractured Jaw	Low Blood Pressure	Tobacco Use / Vaping
Cancer	Glaucoma	Osteoporosis	Transplant Surgery
Diabetes	High Blood Pressure	Psychiatric Treatment	Tuberculosis

11. Any other medical condition not listed above? _____
12. Do you wear an orthodontic retainer, mouth guard, or bruxism splint? ☐ YES ☐ NO

FOR WOMEN ONLY: *(PLEASE CIRCLE)*

Pregnant (___/mos)	Y	N	Taking Birth Control Pills	Y	N
Nursing	Y	N	On a Fertility Program	Y	N

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform West Village Dental Centre of any changes in medical status.

_____
Signature

** OFFICE USE ONLY **
MEDICAL HEALTH UPDATES

D	M	Y	NOTES