

## PATIENT MEDICAL HISTORY

	yes	no
1. Are you now under the care of a physician? What is the condition being treated? _____		
2. Have you had any serious illness or operation? If yes, what was the illness or operation? _____		
3. Have you ever been hospitalized? If yes, what was the problem? _____		
4. Are you taking any drug or medicine including birth control pills? If yes, what? _____		
5. Do you use tobacco products? Yes ( ) No ( ) Cigarettes? _____ No. per day _____ Pipe _____ Snuff _____ Have you tried to eliminate these products from your life? _____		
6. Are you allergic to or have you reacted adversely to any drug or medicine: eg. local anaesthetic (freezing), penicillin or other antibiotics, barbituates, sedatives, analgesics (pain killers)? _____ If so what? _____		
7. Do you have any of the following? a. Rheumatic fever or rheumatic heart disease _____ b. Birth defects in the heart _____ c. Heart attack, high blood pressure, hardening of the arteries, stroke _____ d. Chest pains or shortness of breath _____ e. Asthma, hay fever or skin rash _____ f. Fainting spells or seizures ( epilepsy ) _____ g. Diabetes _____ h. Kidney disease _____ i. Hepatitis, jaundice or liver disease _____ j. Thyroid disorder _____ k. Lung or breathing disorder _____ l. Stomach/bowel problem _____ m. Nervous disorder _____ n. Bone, muscle or joint disorders: eg. arthritis _____ o. Cancer _____ p. Aids or ARC HIV Positive _____		
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or cuts?		
9. Do you have any blood disorder? _____		
10. Women, are you pregnant? _____		
11. Do you have, or have you had any eating disorder eg. anorexia or bulimia? _____		
12. Do you have any disease or disorder not listed that you think I should know about? If yes, what? _____		

### TREATMENT CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.

Signature of patient ( parent, guardian ) \_\_\_\_\_ Date \_\_\_\_\_