Name _____ Date _____

Medical History (please complete the front page only)

If you are unsure or if you have any questions, please consult with a member of the staff

	YES	NO
1. Do you have any medical conditions, past or present? *Please review the MEDICAL CONDITION LIST and tell a team member any that apply* _____ _____	☐	☐
2. Have you been hospitalized in the past 2 years? _____	☐	☐
3. Have you recently, or are you presently, taking any prescription or non-prescription medications, including herbal remedies? Please list on the bottom of this page	☐	☐
4. Have you ever had an adverse ("allergic") reaction to any medications or injections? If yes, please circle: penicillin, other antibiotics, latex, codeine, local anaesthetic (freezing) Other medications _____	☐	☐
5. Do you bleed excessively from a cut or bruise very easily?	☐	☐
6. Do you smoke (cigarettes, e-cigarettes, marijuana) or use other forms of tobacco?	☐	☐
7. Are you alcohol and/or drug dependent?	☐	☐
8. Is there anything else about your health that we should be made aware of?	☐	☐
9. Do you wish to speak to the doctor privately about any problem or medical condition?	☐	☐
10. Are you pregnant or suspect that you may be?	☐	☐

To the best of my knowledge, the above information is correct. Patient's Initials: _____

I have reviewed the Medical Condition List Patient's Initials: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Medications being used at first visit:

Medication Name:_____ Reason for taking _____

_____ _____

_____ _____