EASTGATE DENTAL CONFIDENTIAL MEDICAL HISTORY

Patient ____________________________________ **Dr.** ___________________

Physician's name _____________________________________ Phone # _____________________________________

1. Are you in good health? Yes _____ No _____ If no, please provide details ______________________________

   ____

2. When was the last time you had a medical examination? ____

3. Are you presently receiving treatment for any illness? If yes, please provide details: ________________________

   ____

4. Have you ever been hospitalized? If yes, please provide details: _______________________________________

   ____

5. Do you have any heart or circulatory problems? Yes ___ No ___ Do you have a pacemaker? Yes ___ No ___
6. Have you ever had rheumatic fever? Yes ___ No ___ If yes, when _______________
7. Have you ever been advised to take antibiotic pre-medication prior dental treatment? Yes ___ No ___
8. Do you have allergies? Seasonal/hayfever ____ Food _________________ Medication _________________

   ____

9. Are you presently taking any kind of medication? If yes, please specify:
   Drug ___________________________________ Reason ____
   Drug ___________________________________ Reason ____
   Drug ___________________________________ Reason ____

   PHARMACY ____ tel. ______________________________

10. Have you ever had a reaction to any kind of medicine or dental local anesthetic? If yes, please provide details:

    ____

11. Female patient – Are you pregnant or thinking you may be pregnant? Yes ___ No ___ Breastfeeding? ________
12. Please indicate below (ɤ) If you presently have or have ever had any of the following:

- ☐ AIDS/HIV
- ☐ Alcohol or chemical dependency
- ☐ Arthritis or Rheumatism
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer/radiotherapy/chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/dizzy spells
- ☐ High/low blood pressure
- ☐ Hyper/hypo glycemia
- ☐ Kidney disease
- ☐ Liver disease (Hepatitis/Jaundice)
- ☐ Lung disease/chest pains
- ☐ Mental/nervous disorder
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal/Communicable disease
- ☐ High cholesterol

13. Do you smoke? If yes, haw much per day? _________________ Per week __________________
14. Do you grind or clench your teeth: Yes _____ No _____
15. Do you suffer from headaches ______ Earaches ______ Neckaches ______
16. Is there any additional information related to your health that has not been addressed above? ______________

____

________________________________	_______________	__________________________	_______________
Patient or guardian signature	**Date**	**Reviewed by**	**Date**