Patient Medical Information

Dr. Wendy Low Dentistry Professional Corp.

Title ______ **First Name** ______ **Surname** ______

Health Card Number ______ **Email** ______

Date of birth ______ **Occupation** ______ **Employer** ______

Address ______ **Referred By** ______

______ **Postal Code** ______

Tel Contact **Home:** ______ **Work:** ______

Mobile: ______

Emergency Contact ______ **Emergency Contact Number** ______

Are you being treated for any medical condition at the present or or have you been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? ______

When was your last medical check-up? ______

Has there been any change in your general health in the last year?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Are you taking any medications, non-prescription drugs or herbal suplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list ______

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications ______

Latex/Rubber Products ______

Other (e.g. Hayfever, Foods) ______

Have you ever had a peculiar or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you have or have you ever had asthma?
Yes ☐ No ☐ Not Sure ☐

Type of puffer ______

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? ______

Do you have a prosthetic or artificial joint?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you have bleeding problem or bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

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Have you ever been hospitalized for any illness or operations? Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______________________________

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any of the following? Please Check

☐ Alzheimers	☐ Digestive Disorders / Acid Reflux	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever
☐ Angina	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Sexually Transmitted Infection
☐ Anemia	☐ Emphysema	☐ Lung Disease	☐ Shortness of Breath
☐ Arthritis	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Blood Transfusion	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Cancer	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Chest Pain	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Cold Sores	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Diabetes Type 1	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 2	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	☐ Tuberculosis

Are there any conditions or disease not listed above that you have or have had? Yes ☐ No ☐ Not Sure ☐

If yes, please list ______________________________

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______________________________

Do you smoke or chew tobacco products? Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment? Yes ☐ No ☐ Not Sure ☐

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Dentist .... **Tel** ....

Address ....

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The Information I have given above is true to the best of my knowledge.

Patient Signature .... **Date** ....