DECK DENTISTRY | Your Medical History

Name ____________________ (Surname) ______________ (First Name(s)) ______________ (Your Preference) Date of Birth ___ / ___ / ___ (D M Y)

How would you describe your health? ☐ Good ☐ Fair ☐ Poor *(explain)* ________________________

Are you presently under treatment or observation by a doctor ☐ Yes ☐ No

Doctor's Name: ____

Reason for treatment: ____

Name of your pharmacy: ____

List any medications you are taking *(prescribed or self-administered)*:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Are you currently receiving Cancer treatment or taking any medication for Cancer? ☐ Yes ☐ No

(If so, please explain) ____

Have you had any reactions to any of the following medications?

☐ Penicillin ☐ Erythromycin ☐ Other antibiotics ☐ Aspirin ☐ Codeine

☐ Local anesthetic (dental freezing) ☐ Other *(details)* ____________________

Do you have any allergies? ____

Do you have any reaction to latex? ____

Are you a smoker? ☐ Yes ☐ No If yes, how much a day? _________ How long? ___________

Do you take any herbal or natural supplements? ____

Do you require pre-medication before dental treatment? ____

Do you have or have you had any of the following?

CARDIOVASCULAR
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Heart surgery
- ☐ Angina
- ☐ Cardiac pacemaker
- ☐ Shortness of breath
- ☐ High/Low blood pressure
- ☐ Stroke

BLOOD
- ☐ Easily bruised
- ☐ Prolonged bleeding
- ☐ Blood transfusions
- ☐ Blood disorders
- ☐ HIV / AIDS

KIDNEY
- ☐ Kidney disease
- ☐ Prostate disease

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Sinusitis
- ☐ Tuberculosis

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems

LIVER
- ☐ Cirrhosis
- ☐ Jaundice
- ☐ Hepatitis

GASTROINTESTINAL
- ☐ Ulcers
- ☐ Medicine intolerance

JOINTS
- ☐ Hip /other replacement

Date: ____________

MISCELLANEOUS
- ☐ Cold sores

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

If *yes*, how many months? ____________

Have you ever been hospitalized? ☐ Yes ☐ No Date _______ Reason ______________________________

I have read and answered all of the questions above, and I certify that the information is complete and correct to the best of my knowledge.

Patient *(Parent or Guardian)* Signature ______________________________ Date ______________

Dentist's Signature ____