NORTHLAND DENTAL GROUP

# PATIENT MEDICAL HISTORY FORM

☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master

First Name _____ Last Name _____

Date of Birth _____

Please mark the checkboxes with an "X" if applicable to you.
Have you ever had / experienced?

| | | | |
|---|---|---|---|
| ☐ Heart trouble | ☐ A Stroke | ☐ Chest trouble | ☐ High blood pressure |
| ☐ Asthma | ☐ Arthritis | ☐ Rheumatism | ☐ Rheumatic fever |
| ☐ Diabetes | ☐ Fits or epilepsy | ☐ Hepatitis | ☐ Tuberculosis |
| ☐ HIV/AIDS | | | |

Please mark the checkboxes with an "X" if applicable to you.

☐ Do you smoke?
☐ Are you pregnant?
☐ Have you ever taken Bisphosphonates?
☐ Are you presently under medical care or taking any medicines or tablets?
If yes, please give details _____

_____

_____

☐ Do you have any artificial joints, heart valve or other prosthetic implant? Provide details.

_____

☐ Have you had a problem with bleeding needing special treatment? e.g. After extractions
☐ Have you had an allergy or a bad reaction to any medicine, product or substance?
e.g. aspirin, penicillin, latex, house dust or pollen
If yes, please list allergy/bad reaction(s) _____

_____

☐ Have you had a bad reaction to dental treatment?
☐ Have you ever been a patient in hospital?
If yes, please list reason(s) _____

_____

## YOUR MEDICAL DOCTOR DETAILS

First Name_____ Last Name _____

Address _____

Mobile/ Phone _____

## DECLARATION

I have completed this confidential questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk.

Signed _____ Date _____

Checked by dentist _____

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