COURTENAY DENTAL HEALTH

Full Name:		Birthdate:	

Are you presently under a Physician's care for chronic medical conditions?	

What drugs / medications are you currently taking (including Aspirin and Vitamins)?
if you cannot remember, we can call your pharmacy , extra space on second page.

Have you been hospitalized in the last 5 years? If yes, for what condition?

Do you have any allergies (e.g. Latex, Penicillin)?	
Do you require PRE-MEDICATION FOR ANY DENTAL APPOINTMENTS?	
Do you have any artificial body parts (e.g. Health Valve, Joints, Pacemaker)?	
Do you have any ingections we should be aware of?	
Do you take or have you taken in the past bisphosphonates, blood thinners, methotrexate?	

UPDATED MEDICAL HISTORY

We required, by The College of Dental Surgeons of BC, to have an updated medical history completed every 2 years, thank you for you cooperation

Do you have or have you had any of the following: (it is important that you answer accurately). *Please mark with "X"*.

	YES	NO		YES	NO
Hearth conditions (including heart attack)			Osteoporosis / osteopenia		
History of infective endocarditis			Hepatisis (A, B or C)		
History of stroke			Cancer / radiation/ chemotherapy / tumor		
High or low blood pressure			Thyroid problems		
Diabetes (Type ___) A1C ___ Date _____			Prolonged bleeding from a minor cit		
Lung problems (COPD, emphysema)			Neurologic disorders (ADD / ADHD etc.)		
Asthma or sinus problems			Mental health disorders		
Liver disease or jaundice			Do you identify as a person with a disabilitiy?		
Kidney disease			Frequent headaches		
Stomach problems or ulcers			Sleep apnea or other sleeping issues		
Tuberculosis, chicken pox, measles			Use alcohol or other recreational drugs (including marijuana)		
Epilepsy or nervous problems			If yes, did you use in the last 24 hours?		
Arthritis			Do you smoke cigarattes? How much? _____		
Digestive disorders (Celiac, acid reflux)					
Blood Disorders (Anemia etc.)			**WOMEN:**		
Autoimmune diseases (Lupus etc).			Are you pregnant?		
HIV / AIDS			Are you nursing?		
Cold sores / Viral Infections (STI / HPV)			Are you post menopause?		

Any other concerns to note that are not mentioned above? (Room for documentation on the second page)

Date:		Signature of Patient:		Reviewed By:	

Extra Notes Regarding your Medical History