GARDEN DENTAL
& ORTHODONTICS

MEDICAL HISTORY UPDATE

INFORMATION YOU GIVE US IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN PERMISSION. TO HELP US PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE, PLEASE PROVIDE US WITH COMPLETE INFORMATION AND DON'T SKIP ANY QUESTIONS. WE WILL REVIEW THE QUESTIONNAIRE AND DISCUSS IT WITH YOU IN DETAIL. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK THE DENTIST.

☐ Mr ☐ Mrs ☐ Ms ☐ Dr	Date of Birth DD / MM / YYYY	Last Name
First And Middle Names:		Preferred Name

1. When was your last medical examination?	2. Purpose:
3. Have you been treated for any medical condition within the past year? ☐ YES ☐ NO	Details
4. Have you traveled outside Canada within the last year? ☐ YES ☐ NO	Destination
5. Have you had an unusual or persistent cough or rash in the past 3 weeks that has not been examined by your family doctor? ☐ YES ☐ NO	
6. Has there been any change in your general health in the past year? ☐ YES ☐ NO	Details
7. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ YES ☐ NO	Please list
8. Are you allergic to or have you had adverse reactions to any of the following? (please check all that apply): ☐ Local Anaesthetics ☐ Barbiturates or Sedatives ☐ Penicillin or Other Antibiotics ☐ Aspirin ☐ Iodine ☐ Bisphosphonates ☐ Latex or Rubber ☐ Codeine ☐ Sulfa Drugs ☐ Any metals (like Nickel, Mercury etc) ☐ Other (please list)	
9. Have you ever had a peculiar or adverse reaction to any medications or injection/anaesthetic? ☐ YES ☐ NO	Details
10. Do you have, or have you ever had, endocarditis, a prosthetic heart valve, heart transplant or other heart surgery? ☐ YES ☐ NO	
11. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO	
12. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ YES ☐ NO	
13. Do you have any conditions or therapies that could affect your immune system like leukemia, radiotherapy, chemotherapy, transplant surgery? ☐ YES ☐ NO	

14. Do you have a bleeding problem or bleeding disorder? Do you bruise easily?
☐ YES ☐ NO

15. Have you ever been hospitalized for any serious illness or major surgery?
☐ YES ☐ NO

Details

16. Do you have or have you ever had any of the following? (Please check all that apply)

☐ heart disease	☐ hepatitis	☐ chest pain, angina	☐ shortness of breath	☐ pacemaker
☐ steroid therapy	☐ seizures(epilepsy)	☐ heart attack	☐ lung disease	☐ diabetes
☐ kidney disease	☐ tuberculosis	☐ thyroid disease	☐ swollen ankles/feet/hands	
☐ stroke	☐ stomach ulcers	☐ anxiety disorder	☐ eating disorder	☐ low blood sugar
☐ drug dependency	☐ alcohol dependency	☐ glaucoma	☐ cancer	☐ arthritis
☐ diet pill therapy	☐ asthma	☐ HIV/AIDS,	☐ rheumatic fever	☐ liver disease
☐ jaundice	☐ cochlear implant	☐ high/low blood pressure		
☐ other (please describe)				

17. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
☐ YES ☐ NO

Details

18. Do you smoke or chew tobacco or cannabis products?
☐ YES ☐ NO

Details

19. Are you breast-feeding or pregnant? ☐ YES ☐ NO

Due Date

20. Do you have any other disease, disorder or condition not listed above?
☐ YES ☐ NO

Details

Please indicate your 21. Height ft in 22. Weight lbs

CONSENT:

☐ I certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information.

☐ I hereby authorize the taking of radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

☐ I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I understand that the use of medications, anesthetics and some procedures embody a certain risk. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.

☐ I understand the need for these questions to be answered truthfully and that providing inaccurate information can be dangerous to my health. To the best of my knowledge, the answers I have given are complete and accurate. I also understand that it is my responsibility to inform Garden Dental of any changes or updates in my medical status, including new medications.

➡ PATIENT/ PARENT/GUARDIAN SIGNATURE: _____ DATE _____

➡ DENTIST SIGNATURE: _____ DATE _____