SOUTHGATE
SURGICAL SUITES

Dentist Providing Treatment

CONFIDENTIAL MEDICAL HISTORY

PATIENT'S FIRST & LAST NAME			ALBERTA HEALTH CARE NUMBER		
ALLERGIES	☐ Male ☐ Female	HEIGHT	WEIGHT	AGE	BIRTH DATE YY-MM-DD
List of any past HOSPITALIZATIONS or SURGERY					
List current MEDICATIONS, herbal products, non-prescription drugs, ointments or supplements (name, dose, frequency)					

Do you have a history of:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Heart Attack			Sickle Cell Disease			Diabetes		
Congestive Heart Failure			Asthma			High Blood Pressure		
Heart Murmur			Tuberculosis			Kidney Problems		
Immunizations			Sleep Apnea or COPD			Urinary Problems		
Stroke			Jaundice			AIDS/HIV		
Pace Maker			Hepatitis			Heartburn/Acid Reflux		
Artificial Heart Valve			Liver Disease			Thyroid Disease		
Congenital Heart Disease			Bruising Easily			Epilepsy or Seizures		
Swollen Ankles			Psychiatric Care			Concussion		
Rheumatic or Scarlet Fever			Anxiety Disorders			Cancer		
Fainting or Dizziness			Depression			Radiation or Chemo		
Anemia			Artificial Joint			Alcohol Use		
Blood Clots			Neuromuscular Disorder			Recreational Drug Use		
Hemophilia			Arthritis			Cortisone/Steroid Use		

Please answer the following questions:	**YES**	**NO**	**NOTES**
Do you see a family physician or specialist physician on a regular basis?			
Are you disabled in any way?			
Are you on a special diet? Is it on the advice of a physician?			
For Women, last menstrual period? YY-MM-DD			
Are you taking blood thinners or aspirin? If so, why?			
Do you suffer from osteoporosis?			
When you walk up the stairs or walk several blocks do you get short of breath, chest pain or excessively tired?			
Is there a personal or family history of allergies or unfavorable reaction to local or general anesthetics?			
Do you have a personal or family history of malignant hyperthermia?			
Do you have a personal or family history of pseudo cholinesterase deficiency?			
Do you smoke tobacco? If so, how much and for how many years?			
Do you have any jaw joint (TMJ) problems, or jaw muscle problems?			
Is there anything else about your medical history you feel we should know?			

Name of Person Providing Information _____ Relationship to Patient _____
PRINT

Date _____ Signature _____