Living Wellness Dental

(587) 600-6935

Medical History

THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE, AND IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. YOUR DENTIST WILL REVIEW THE QUESTIONS AND EXPLAIN ANY THAT YOU DO NOT UNDERSTAND. PLEASE FILL IN THE ENTIRE FORM.

1. When was your last medical check-up? ___________________________ Height: ___________ Weight: ___________

2. Name & phone number of physician ____

3. Are you being treated for any medical condition at the present, or have you been treated within the past year? Yes□ No□

   If yes, why? ____

4. Has there been any change in your general health in the past year? Yes□ No□

   If yes, please explain: ____

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes□ No□

6. Do you have any allergies? Yes□ No□

   a) medications b) latex/rubber products c) other- e.g. hay fever, foods

7. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes□ No□

8. Do you have, or have you had blood pressure problems? If yes, please explain. Yes□ No□

   High BP □ Low BP □

9. Do you have, or have you ever had heart disease? Yes□ No□

10. Do you have a bleeding disorder? Yes□ No□

    If yes, please explain: ____

11. Do you have, or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes□ No□

12. Do you have a prosthetic or artificial joint? Yes□ No□

13. Do you have any conditions or therapies that could affect your immune system?
    Ex. Leukemia, chemotherapy, Radiotherapy, AIDS, HIV infection, etc? Yes□ No□

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14. Do you have a genetic disorder? Yes□ No□

If yes, please explain: ______________________________

15. Have you had a head injury? Yes□ No□

If yes, please explain: ______________________________

16. Do you smoke or chew tobacco? Yes□ No□

If yes, how much? ______________________________

17. Are you using or do you take:

Blood thinners □	Contact lenses □	Contraceptives □	Diet pills □
Pacemaker prosthetic □	Heart Valve □	Steroid therapy □	Other:______________

18. Do you have or have you ever had: (please check those that apply)

□Stroke	□Stomach/GI disorder	□Lyme's disease	□Hepatitis C	□Parkinson's disease
□Dementia	□Anemia	□Lung disease	□ALS	□Seizures/epilepsy
□Glaucoma	□Acid reflux	□Nervous system	□Asthma	□Kidney disease
□Rheumatoid	□Tuberculosis	□Thyroid disease	□Sinus problems	□Cancer
□STD's	□Osteoarthritis	□Canker sores	□Auto immune disorder	□Hearing disability
□ Anxiety drug/alcohol	□ Dependency	□Shortness of breath	□Dizziness/fainting	□Eating disorder
□Depression	□Sleep apnea	□Diabetes	□Osteoporosis	□Hepatitis B
□Arthritis	□Eating disorder	□Multiple Sclerosis	□Other: ______________	

19. Are there any conditions or diseases not listed above that you have or have had? Yes□ No□

If yes, please explain: ______________________________

20. For women: Are you breast feeding or pregnant? Yes□ No□

If pregnant, what is the expected delivery date______________________________

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Please list prescription medications and dosages:

Medication	**Dosage**
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
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______________________________	______________
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Please list supplements:

Supplements:

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To the best of my knowledge, the above information is correct.

____________________	____________________	____________
Print Name	Signature	Date