HEALTH HISTORY

Office Name:	Office Phone:	Office Address:	City and Prov\State:	Postal\Zip Code:
Joseph Howe Family Dentistry	(902) 445-5433	3711 Joseph Howe Drive, Unit 3	Halifax, NS	B3L 4H8

Patient Name:	Home Phone:	Date:	PID:

Address 1:	Address 2:	City and Prov\State:	Postal Code:

Email Address:

D.O.B:

Occupation:

MEDICAL ALERT:

Condition:

Premedication:

Usual Dentist:

Hygienist:

	Medical History Questions:	YES	NO
1.	Have you visited a physician for a medical condition in the past two years?	☐	☐
	If yes, please explain.		
	Physician :		
	Phone :		
2.	When was your last visit to a Physician?		
	Last complete physical examination?		
3.	Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Or have you recently taken any?	☐	☐
	If yes, please list:		
4.	Have you been hospitalized in the past two years?	☐	☐
5.	Have you ever reacted adversely to any of the following?		
	• Antibiotics - Penicillin.	☐	☐

	• Sulfonamide.	☐	☐
	• other antibiotics.	☐	☐
	• Aspirin.	☐	☐
	• Barbiturates (sleeping pills).	☐	☐
	• Codeine.	☐	☐
	• Darvon.	☐	☐
	• Local Anesthetic (freezing).	☐	☐
	• Nitrous oxide.	☐	☐
	Any other medication, please list.		
6.	Have you ever been advised against taking any specific type of medication?		
7.	Do you have any of the following?		

	Yes	No		Yes	No
Asthma.	☐	☐	Hay Fever.	☐	☐
Food Allergies.	☐	☐	Metal or Latex Allergies.	☐	☐
Skin Rashes.	☐	☐	Hives.	☐	☐
Any other allergic condition.	☐	☐			

8.	Has any family member had diabetes?	☐	☐
9.	Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐	☐
10.	Do your ankles, feet or hands swell?	☐	☐
11.	Has your weight, appetite or energy level changed dramatically recently?	☐	☐
12.	Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
13.	Do you follow a special diet?	☐	☐
14.	Have you recently tested HIV positive?	☐	☐
15.	Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	☐	☐
16.	Have you ever had any injury or surgery to your face or jaws?	☐	☐
17.	Do you wear eyeglasses or contact lenses?	☐	☐
18.	Do you have any hearing difficulties?	☐	☐
19.	Do you smoke or use any other forms of tobacco?	☐	☐
	• Are you wearing the transdermal nicotine patch?	☐	☐
20.	Are you alcohol and/or drug dependent?	☐	☐
	• Have you received treatment?	☐	☐
21.	INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:		

	Yes	No		Yes	No		Yes	No
A.I.D.S.	☐	☐	Anemia	☐	☐	Angina pectoris	☐	☐
Arthritis/ rheumatism	☐	☐	Artificial heart valve	☐	☐	Artificial joints (hip, knee)	☐	☐
Blood disorders	☐	☐	Bronchitis	☐	☐	Cancer	☐	☐

	Circulation problems	☐	☐	Congenital heart lesions	☐	☐	Cortisone/ steroid	☐	☐
	Diabetes	☐	☐	Emphysema	☐	☐	Epilepsy or seizures	☐	☐
	Fainting or dizzy spells	☐	☐	Glandular disorders	☐	☐	Glaucoma	☐	☐
	Head/neck injuries	☐	☐	Heart disease or attack	☐	☐	Heart murmur	☐	☐
	Heart pacemaker	☐	☐	Heart rhythm disorder	☐	☐	Heart surgery	☐	☐
	Hepatitis A	☐	☐	Hepatitis B	☐	☐	Hepatitis C	☐	☐
	Herpes	☐	☐	High/Low blood pressure	☐	☐	Hodgkins disease	☐	☐
	Hyper (Hypo) Glycemia	☐	☐	Hypertension	☐	☐	Jaundice	☐	☐
	Kidney disease	☐	☐	Liver disease	☐	☐	Lung disease	☐	☐
	Malignant hyperthermia	☐	☐	Mental/nervous disorder	☐	☐	Mitral valve prolapse	☐	☐
	Organ transplant/ medical transplant	☐	☐	Psychiatric treatment	☐	☐	Radiation treatment/ chemotherapy	☐	☐
	Rheumatic/ Scarlet fever	☐	☐	Sickle cell disease	☐	☐	Sinus trouble	☐	☐
	Stomach/ intestinal problems	☐	☐	Stroke	☐	☐	Thyroid disease	☐	☐
	Tuberculosis	☐	☐	Ulcers	☐	☐	Venereal disease	☐	☐
	Other								

22. Has the CHILD PATIENT recently had any of the following (indicate approximate date):

		Yes	No			Yes	No
Measles		☐	☐	Mumps		☐	☐
Chicken Pox		☐	☐	Strep throat		☐	☐
Tonsillitis		☐	☐				

23. **WOMEN ONLY:**

- Are you pregnant or suspect you might be? ☐ ☐
- If yes, what is the expected birth date? _____
- Are you taking any birth control pills? ☐ ☐

24. Do you currently have, or have you had in the past, any disease, condition, or problem not listed above?

25. Is there anything else about your health we should be made aware of?

26. Do you wish to speak to the Doctor privately about any problem or medical condition? ☐ ☐

Guardian/Patient Signature: _____ Date: _____