Caradoc Dentistry

28498 Centre Road, Strathroy, ON, N7G 3H6
Phone: 519-245-0751
Email: info@caradocdentistry.com
www.caradocdentistry.com/

Medical History Form

Patient Name: _____ Date of Birth (DD/MM/YYY) _____

Do you have a family doctor? ◯ YES ◯ NO Name: _____

Are you hard of hearing? ◯ YES ◯ NO

Do you wear glasses? ◯ YES ◯ NO Do you wear contact lenses? ◯ YES ◯ NO

Do you smoke? ◯ YES ◯ NO Do you use recreational drugs? ◯ YES ◯ NO

Do you consume alcohol? ◯ YES ◯ NO If so, how many beverages would you consume in a week? _____

WOMEN ONLY Are you pregnant? ◯ YES ◯ NO If so, what month are you in? _____

Do you take birth control pills? ◯ YES ◯ NO

Have you ever been told you need to take medication before coming to the dentist? ◯ YES ◯ NO

If so, what type? _____

Do you take any prescription medication? ◯ YES ◯ NO

Please list medication and dose: _____

_____

Do you take any non-prescription medication or supplement? ◯ YES ◯ NO

Please list any supplements or non-prescription medication and dose: _____

_____

Do you have any allergies? ◯ YES ◯ NO

Medications: _____

Latex/Rubber Products: _____

Others (Food/Hay Fever): _____

Have you ever had any injury, surgery, or radiation to your face or jaw? ◯ YES ◯ NO

Have you had your wisdom teeth removed? ◯ YES ◯ NO

Do you have frequent headaches, TMJ, grinding, or clenching? ◯ YES ◯ NO

Do you grind your teeth? ◯ YES ◯ NO

Have you ever had a throat infection? ◯ YES ◯ NO

Are you taking blood thinners? ◯ YES ◯ NO

Are you taking bone strengthening medication? ◯ YES ◯ NO

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

- ☐ Heart murmur or mitral valve prolapse
- ☐ Stomach or intestinal problems
- ☐ Joint replacement (hip, knee, etc)
- ☐ Mental or nervous disorder
- ☐ High or low blood pressure
- ☐ Hyper or hypo glycemia
- ☐ Epilepsy or seizures
- ☐ Malignant hyperthermia
- ☐ Drug or alcohol addiction
- ☐ Venereal disease
- ☐ Any lung disease
- ☐ Thyroid disease
- ☐ Arthritis or rheumatism
- ☐ Scarlett or rheumatic fever
- ☐ AIDS
- ☐ Positive testing for HIV virus
- ☐ Jaundice
- ☐ Diabetes, If so what type: _____
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ Heart attack
- ☐ Cold sores
- ☐ Cancer
- ☐ Kidney disease
- ☐ Sinus trouble
- ☐ Liver disease
- ☐ Cortisone/steroid therapy
- ☐ Asthma
- ☐ Dizziness
- ☐ Excessive bleeding/bruise easily
- ☐ Nervous

Other: _____

Is there anything else you would like us to be aware of? _____

Informed Consent

I, the undersigned, have provided a complete and accurate Medical/Dental History. To the best of my knowledge, the above information is correct. I authorize the dentist to contact my physician if necessary. I authorize the dentist to perform diagnostic, dental, and oral surgery procedures and services, including the use of anaesthetic as may be necessary. I also understand and assume any and all fees associated with these procedures and services provided to me or my dependents. If I ever have any change in my health or medications, I will inform the dental team at Caradoc Dentistry at the next appointment without fail.

Patient Signature (Parent/Guardian):_____Date: _____