BRUNSWICK DENTAL FAMILY PRACTICE

HEALTH HISTORY

Office Name:	Office Phone:	Office Fax:
BRUNSWICK DENTAL LTD	(441)292-2838	(441) 292-4577
Office Address:	**City and Prov\State:**	**Postal\ZipCode:**
P.O. Box HM1469	Hamilton	HMFX

Patient Name:	Home Phone:	Date:	PID:
Address 1:	**Address 2:**	**City and Prov\State:**	**Postal\Zip Code:**

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: