PACIFIC SPIRIT
DENTAL CENTRE

An accurate and complete health history is essential in planning and performing proper care.
All information is strictly confidential.

PATIENT:____**DATE**________________________________

(A) GENERAL

1. Do you consider your health to be good? ____Yes No
2. Have you any serious illness(es)or operations____Yes No
   If yes, please explain. ____

   ____
3. Has there been any recent change in your health? _______________________________________Yes No
   If yes, please explain____
   ____
4. Are you presently being treated by your physician or specialist? ____________________________ Yes No
   If yes, please explain. ____
   ____
5. Are you taking any prescription or non-prescription (e.g. Tylenol, Advil, aspirin, etc.) medications____Yes No
   (It is important to inform us if you are taking drugs such as Cialis, Levitra, Staxyn, Viagra herbal remedies and/or "recreational drugs")
   Please list all medications: ____
   ____
   ____
6. Are you allergic to any medications? E.g. Penicillin, Erythromycin, etc.__________________________ Yes No
   If yes, which medications? ____
7. Are you allergic to latex? ____ Yes No
8. Do you smoke or use tobacco products? If yes how many per day? ____________________________ Yes No
9. Do you consume alcohol? If yes, how many drinks per day? _________________________________ Yes No

(B) SPECIFIC

10. Do you have heart disease? E.G. coronary artery disease, pacemaker, artificial valves, heart attack, etc.? ____ Yes No
11. Breathing Problem's? E.g. Asthma, emphysema, TB, etc. ____________________________________ Yes No
12. High or low blood pressure? ____ Yes No
13. Stroke? ____ Yes No

14. Blood disorders? E.g. Anemia, hemophilia, prolonged bleeding disorders, excessive bruising? ______ Yes No
15. Diabetes? Type I? Type II? ______ Yes No
16. Thyroid excess or insufficiency? ______ Yes No
17. Kidney problems? Dialysis? ______ Yes No
18. Liver problems? E.g. Hepatitis, cirrhosis? ______ Yes No
19. Stomach or digestive problems? ______ Yes No
20. Arthritis? If so, what type? ______ Yes No
21. Artificial joints? Which ones? ______ Yes No
22. Allergies and/or sensitivities? ______ Yes No
23. Cancer? If yes, what type and when? ______ Yes No
24. HIV positive (AIDS)? ______ Yes No
25. STDs (sexually transmitted diseases) ______ Yes No
26. Cold Sores? ______ Yes No
27. Nervous disorders? e.g. Parkinson's Disease, MS, Etc. ______ Yes No
28. Psychiatric disorders? ______ Yes No
29. Trauma to head or face? ______ Yes No
30. Frequent headaches? ______ Yes No
31. Do you were contacts or have vision problems? E.g. Glaucoma? ______ Yes No
32. Have you ever had minimal or moderate sedation? When? ______ Yes No
33. Any history of familial sedation/anesthetic complications? ______ Yes No
34. Do you have OSA (Obstructive Sleep Apnea)? ______ Yes No

(C) WOMEN ONLY

35. Are you pregnant? If yes, when is you due date? ______ Yes No
36. Are you using contraceptives? ______ Yes No

(D) Are there any problems which have not been covered above but which you feel the dentist should know about?

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______

______

______

Patients Signature: ______ **Date**: ______

Dentist's comments:

______

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Dentist's Signature: ______ Date: ______