PLACE D'ORLEANS DENTAL OFFICE

MEDICAL PROFILE

NAME OF PATIENT: ______________________ TEL.(HOME): ______________________

ADDRESS: ______________________ TEL.(WORK): ______________________

______________________ CELL.: ______________________

______________________ EMAIL: ______________________

IF YOU REQUIRE ASSISTANCE COMPLETING THIS FORM, PLEASE NOTIFY THE RECEPTIONIST.

Our dental practrice strives to maintain a safe and professional environment for both patients and staff. It is our primary goal to provide you with the best dental care possible. The questions on this form are important to our practice so that our standards of safety, professionalism and treatment can be upheld. Your answers to these questions may affect the types of treatment that are appropriate for your dental health care. All responses to these questions will be kept in strict confidentiality.

Please note: if you are completing this form for your child or ward, "you" and "your" always refer to your child's or ward's medical history.

MEDICAL PHYSICIAN ______________ TEL ______________ MEDICAL SPECIALIST ______________ TEL ______________

Y ☐ N ☐ Do you believe that you are in good health?

Y ☐ N ☐ Have there been any notable changes in your health in the past 2 years?

If YES, please describe your health changes: ______________________

Y ☐ N ☐ Have you been hospitalized in the past 2 years?

If YES, please describe the reason(s) for hospitalization: ______________________

Y ☐ N ☐ Are you allergic or have you ever reacted adversely to any drug, medication or anaesthetic (including painkillers and antibiotics)?

If YES, please indicate the substance(s) and reaction(s): ______________________

Y ☐ N ☐ Have you recently taken or are you currently taking any prescription medications of ANY KIND?

If YES, please indicate the prescription medications: ______________________

Y ☐ N ☐ Have you recently taken or are you currently taken NON-prescription medications of ANY KIND?

If YES, please indicate the non-prescription medications: ______________________

Y ☐ N ☐ Have you been prescribed antibiotics coverage for past dentistry?

If YES, please describe the antibiotics and why they were required: ______________________

Y ☐ N ☐ Do you believe that you are pregnant?

If YES, please specify your due date: ______________________

Y ☐ N ☐ Are you taking birth control pills?

Y ☐ N ☐ Do you smoke or use tobacco of any kind?

Y ☐ N ☐ Do you smoke or use recreational drugs of any kind?

Y ☐ N ☐ Does your family have a history of malignant hyperthermia?

Are you prone to:

Y ☐ N ☐ faintings?
Y ☐ N ☐ dizzy spells?
Y ☐ N ☐ loss of consciousness?
Y ☐ N ☐ epilepsy or seizures?
Y ☐ N ☐ excessive bleeding?
Y ☐ N ☐ bruising easily?

Have you had or been recommended to have surgery for:

Y ☐ N ☐ organ transplants?
Y ☐ N ☐ heart disease?
Y ☐ N ☐ joint replacement?
Y ☐ N ☐ pacemaker?
Y ☐ N ☐ artificial heart valve implant?

Do you have/Have you ever had:

Y ☐ N ☐ learning or behavioural problems?
Y ☐ N ☐ excessive nervousness?
Y ☐ N ☐ communication problems?
Y ☐ N ☐ sensory disorders (seeing/hearing)?
Y ☐ N ☐ heart attack?

Y ☐ N ☐ angina?
Y ☐ N ☐ stroke?
Y ☐ N ☐ diabetes?
Y ☐ N ☐ scarlet fever/rheumatic fever?
Y ☐ N ☐ coronary disease?
Y ☐ N ☐ mitral valve prolapse?
Y ☐ N ☐ heart murmur?
Y ☐ N ☐ congenital heart trouble?
Y ☐ N ☐ arteriosclerosis?
Y ☐ N ☐ high/low blood pressure?
Y ☐ N ☐ eating disorder?
Y ☐ N ☐ unintentional weight gain/loss?
Y ☐ N ☐ cancer?
Y ☐ N ☐ radiation/chemotherapy?
Y ☐ N ☐ urinary tract infection?
Y ☐ N ☐ kidney disease?
Y ☐ N ☐ anaemia?
Y ☐ N ☐ tuberculosis?
Y ☐ N ☐ lung disease?
Y ☐ N ☐ Hodgkin disease?
Y ☐ N ☐ stomach, intestinal or liver problems?

Y ☐ N ☐ thyroid or glandular disorders?
Y ☐ N ☐ blood or blood products transfusion?
Y ☐ N ☐ sickle cell disease?
Y ☐ N ☐ pneumonia?
Y ☐ N ☐ cystic fibrosis?
Y ☐ N ☐ asthma?
Y ☐ N ☐ shortness of breath or difficulty breathing?
Y ☐ N ☐ hay fever?
Y ☐ N ☐ sinus trouble?
Y ☐ N ☐ arthritis?
Y ☐ N ☐ allergy to metal?
Y ☐ N ☐ allergy to latex?
Y ☐ N ☐ allergy to plastic bandages?
Y ☐ N ☐ frequent nose bleeds?
Y ☐ N ☐ blood disorders?
Y ☐ N ☐ HIV infection?
Y ☐ N ☐ AIDS or AIDS related diseases?
Y ☐ N ☐ hepatitis A infection?
Y ☐ N ☐ hepatitis B infection?
Y ☐ N ☐ other hepatitis infection?
Y ☐ N ☐ jaundice?

Y ☐ N ☐ Do you have any other disease, condition or factor in your medical health or history which we should know about?

If YES, please describe the disease, condition or factor: ______________________

If you wish to speak to the doctor privately regarding any questions on this form, please notify the receptionist.

The above medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

☐ Patient
☐ Parent
☐ Guardian

Name ______________________

Signature ______________________ Date ______________

Office notes: ______________________

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Blood Pressure: DIA
SYS

Pulse: BPM

Reviewed by: