KING
DENTAL CENTRE

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Office Phone: _____

	YES	NO
Have you had a medical exam in the last 12 months?	☐	☐
Date of last exam: _____		
Have there been any changes in your general health within the past year?	☐	☐
Have you ever been hospitalized?	☐	☐
Are you now receiving medical treatment?	☐	☐
Are you presently taking any form or medication?	☐	☐
Have you ever been diagnosed or treated for cancer?	☐	☐
Have you ever had heart problems or heart disease?	☐	☐
Have you ever taken diet pills?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Would you like to speak to your dentist privately?	☐	☐

Are you allergic to or have you had a reaction to:

	YES	NO		YES	NO
Local Anesthetics	☐	☐	Antibiotics	☐	☐
Sulfa Drugs	☐	☐	Sedatives	☐	☐
Iodine	☐	☐	Aspirin/Codeine	☐	☐
Metals	☐	☐	Latex Rubber	☐	☐
Specific Foods	☐	☐	Flavors (e.g. Mint)	☐	☐

Other: _____

DOCTOR'S COMMENTS

_____

_____

_____

_____

_____

_____

— MEDICAL ALERT —

Have you ever had and/or been treated for:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Emphysema/Bronchitis	☐	☐	Recent Weight Loss/Gain	☐	☐
Low Blood Pressure	☐	☐	Tonsillitis/Strep Throat	☐	☐	Skin Problems	☐	☐
Swollen Ankles/Feet/Hands	☐	☐	Prolonged Bleeding	☐	☐	Frequent Headaches	☐	☐
Cortisone Treatment	☐	☐	Hemophilia	☐	☐	Frequent Earaches	☐	☐
Kidney Problems	☐	☐	AIDS/HIV Infection	☐	☐	Allergies/Hayfever	☐	☐
Diabetes	☐	☐	Sexually Transmitted Infections	☐	☐	Hives/Skin Rash	☐	☐
Contact Lens	☐	☐	Fainting/Dizzy Spells	☐	☐	Eating Disorders	☐	☐
Glaucoma/Eye Problems	☐	☐	Epilepsy/Seizures	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Asthma	☐	☐	Frequently Tired	☐	☐	Liver Problems	☐	☐
Shortness of Breath	☐	☐	Anxiety/Nervousness	☐	☐	Hepatitis A/B/C	☐	☐
Persistent Cough	☐	☐	Stomach Troubles/Ulcers	☐	☐	Arthritis	☐	☐
Sinus Trouble/Frequent Cold	☐	☐	Drug Addiction	☐	☐	Organ Transplant	☐	☐
Cold Sores/Fever Blister	☐	☐	Alcohol Dependence	☐	☐	Back Problems	☐	☐
Tuberculosis	☐	☐	Psychiatric Care	☐	☐	Artificial Joints/Implants	☐	☐
						Anemia	☐	☐
						Blood Transfusion	☐	☐
						Excessive Bruising	☐	☐
						Osteoporsis	☐	☐

WOMEN ONLY:

	YES	NO
Are you pregnant or think you are pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient or Parent/Guardian Signature: _____ Date: _____

Treating Dentist's Signature: _____ Date: _____