PACIFIC SPIRIT DENTAL CENTRE

215 - 2150 WESTERN PARKWAY
VANCOUVER, BRITISH COLUMBIA
CANADA V6T 1V6
T: 604.224.2411 F: 604.224.6590

CONFIDENTIAL HEALTH HISTORY

PATIENT: _____ Date: _____

Please answer and print appropriate responses. An accurate and complete health history is essential in planning and performing proper care. All information is strictly confidential.

Physician's name and phone number _____

Approximate date of last medical check up _____

(A) GENERAL Please circle

1. Do you consider your health to be good? ..... Yes No
2. Have you been hospitalized or had any serious illness or operation? ..... Yes No
   If yes, please explain _____
   _____
3. Has there been any recent change in your health? ..... Yes No
4. Are you presently being treated by your physician or specialist? ..... Yes No
   If yes, explain _____
   _____
5. Are you taking any medications? If yes, please list names and doses ..... Yes No
   _____
   _____
   _____
   _____
   _____
6. Are you allergic to any medications eg. penicillin or erythromycin? ..... Yes No
7. Do you smoke? If so, how much per day? ..... Yes No

(B) WOMEN ONLY

8. Are you pregnant? If yes, when is due date? _____ Yes No
9. Are you taking oral contraceptives? ..... Yes No

(C) SPECIFICS Please indicate if you have or had any of the following conditions.

10. Rheumatic fever? ..... Yes No
11. Congenital heart disease? ..... Yes No
12. Heart murmur and/or damaged heart valves? ..... Yes No
13. Heart attack? ..... Yes No
14. Congestive heart failure? ..... Yes No
15. Pacemaker, artificial valves or transplants? ..... Yes No
16. Breathing problems eg. asthma, emphysema, etc.? ..... Yes No
17. Tuberculosis? ..... Yes No
18. High or low blood pressure? ..... Yes No
19. Stroke? ..... Yes No
20. Blood disorders eg. anemia, haemophilia, prolonged bleeding, excessive bruising etc.? ..... Yes No

(Please turn over)

21. Blood transfusions? If so, when? _____ Yes No
22. Diabetes (sugar illness)? Yes No
23. Thyroid excess or insufficiency? Yes No
24. Hepatitis, jaundice or liver disease? Yes No
25. Kidney problems or dialysis? Yes No
26. Stomach or intestinal ulcers? Yes No
27. Digestive problems eg. Crohn's disease? Yes No
28. Arthritis? If so, what type and where? _____ Yes No
29. Artificial joints? Yes No
30. Allergies or sensitivities? Yes No

31. Cancer? If so, what type? _____ Yes No
32. Radiation or chemotherapy? Yes No
33. AIDS (Acquired Immune Deficiency Syndrome) or positive testing for AIDS virus? Yes No
34. Venereal disease? Yes No

35. Cold Sores? Yes No
36. Fainting spells, epilepsy or convulsions? Yes No
37. Nervous disorders eg. Parkinson's disease? Yes No
38. Psychiatric disorders? Yes No
39. Trauma to face or head? Yes No
40. Frequent headaches? If so, where? _____ Yes No
41. Vision problems eg. glaucoma? Yes No

Are there any problems which have not been covered above but which you feel the dentist should know about? _____ Yes No

_____

Is there anything in this health questionnaire which you did not understand? Yes No

_____

_____

Patient's Signature: _____ Date: _____

Parent's or Guardian's signature (if under 18):

Dentist's comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dentist's Signature: _____ Date: _____