PATIENT MEDICAL HISTORY

Dr. John McIntosh D.D.S. F.R.C.D.(C).

DATE _____ LEGAL NAME _____ PREFERRED NAME _____
SEX _____ GENDER _____
Health Card/ Driver's Licence (needed for prescriptions) _____
EMERGENCY CONTACT NAME AND PHONE #_____
HEIGHT _____ WEIGHT _____ DOB _____

1. Are you under the care of a physician for any medical problems? Please list.
   _____
   _____
   _____
2. Have you ever had a serious operation, illness or been hospitalized?
   _____
3. Do you have or have you ever had heart valve replacement or repair, an infection of the heart (i.e., infective endocarditis), a heart condition from birth (i.e., congenital heart disease) or a heart transplant, or pacemaker insertion? _____
4. Do you use any recreational Drugs? Please list. _____
5. Do you smoke? How much? For how long? _____
6. Do you consume alcohol? _____ If yes, how many drinks per day? _____ /week _____
7. Do you have any allergies (latex, codeine, penicillin)? Please list.
   _____
8. Is there any chance you are pregnant/ are you breastfeeding? (Please circle)
9. Have you or any family member had a bad reaction to general anaesthesia?
   _____
10. Have you ever been treated for? (please circle and explain below)

Heart Trouble	Psychiatric illness	Stroke/ TIA
Heart Murmur	Arthritis	Thyroid problems
Chest Pain/ Heart Attack	Prosthetic Joints	Bleeding problems
High Blood Pressure	Kidney Problems	Anemia
Swollen Ankles	Diabetes	Liver problems
Persistent cough	Epilepsy/ Seizures	Hepatitis/Jaundice
Asthma/ Bronchitis	HIV/ AIDS	Take blood thinners
COPD/ Emphysema	Cancer	Gastrointestinal Problems
Shortness of Breath	Radiation	Acid Reflux
Snoring/ Sleep Apnea	Chemotherapy	Osteoporosis
Immune System	Steroid Therapy	Stomach Ulcers

   _____
   _____
11. Please list all medications and herbal supplements (including dosage) that you take.
   _____
   _____
   _____
   _____
   _____
   _____
12. Is there anything else we should know about you/ do you have any conditions not listed above?
   _____
   _____
   _____