FERNWOOD
DENTAL

MEDICAL HISTORY

Full Name:_____ Preferred Name:_____

Name of family doctor: _____Family doctor's phone:_____

	Yes	No	Details
Hospitalization within the last 2 years			
Any allergies to medications			
Any other allergies			
History of heart disease (e.g. pacemaker, stent, heart attack, etc.)			
Artificial heart valve			
Joint replacement			
High blood pressure			
Blood disorder			
Prolonged bleeding			
Shortness of breath			
Asthma			
Sleep Apnea			
Diabetes			
Infectious disease eg TB/HIV/AIDS/Hepatitis/HPV			
Head or neck injuries			
Epilepsy, convulsions			
Neurologic disorders			
Cancer			
Radiation Therapy			
Chemotherapy, Immunosuppressive drugs			
Psychiatric treatment			
Depression/Anxiety			
Any other illness			
Frequent headaches			
A smoker (past/present) or smokeless tobacco			
Cannabis			
FEMALE – pregnant			
History of taking bisphosphonates			
Taking blood thinners			

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Drug	Purpose

Patient Signature _____ Date: _____