CONFIDENTIAL HEALTH HISTORY

Parkgate Village Dental Centre

Surname: Mr/Mrs/Ms/Miss/Dr_____ Given Name:_____ Date:_____

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

Physicians Name:_____ Phone Number:_____

Approximate Date of last medical check up:_____

(A) GENERAL

1. Do you consider your health to be good? **Yes/No**

2. Have you ever been hospitalized, had any serious illness or operation? **Yes/No**
If yes please explain:_____
_____
3. Has there been any recent change in your health? Please explain. **Yes/No**

4. Are you presently being treated by a physician or a specialist? **Yes/No**
If yes please explain:_____
_____
5. Are you presently taking any medications? Please list. **Yes/No**

6. Are you allergic or have you reacted adversely to any medications? **Yes/No**
If yes please check below or provide examples_____

Penicillin	Aspirin	Ibubrufen	Sleeping Pills
Erythromycin	Codeine	Sulphonamide (Sulpha)	Valium
Tetracycline	Percodan	Local Anaesthetics	Other Antibiotics
Clindamycin	Demerol	Iodine	

7. Do you smoke? **Yes/No**
8. Do you get chest pains or shortness of breath from strenuous exercise? **Yes/No**
9. Are you allergic to latex gloves? **Yes/No**

(B) FOR WOMEN ONLY

1. Are you pregnant? **Yes/No**
If yes please provide your due date:_____
2. Are you taking birth control pills? **Yes/No**

(C) SPECIFICS

1. Rheumatic fever? **Yes/No**
2. Congenital heart disease? **Yes/No**
3. Heart murmur and / or damaged heart valves? **Yes/No**
4. Heart attack? **Yes/No**
5. Congestive heart failure? **Yes/No**
6. Pace maker? **Yes/No**
7. Artificial valves or transplants? **Yes/No**
8. Angina Pectoris? (pain in the chest)? **Yes/No**
9. Heart Surgery? **Yes/No**
10. Breathing Problems e.g. asthma, emphysema, etc.? **Yes/No**
11. Tuberculosis? **Yes/No**
12. High Blood pressure? **Yes/No**
13. Low Blood pressure? **Yes/No**
14. Stroke? **Yes/No**

15. Blood disorders e.g. anaemia, haemophilia, prolonged bleeding, bruising? **Yes/No**
16. Blood transfusions? If so when? _____ **Yes/No**
17. Diabetes (sugar illness)? **Yes/No**
18. Thyroid excess? **Yes/No**
19. Thyroid Insufficiency? **Yes/No**
20. Hepatitis, jaundice or liver disease? **Yes/No**
21. Kidney problem or dialysis? **Yes/No**
22. Stomach or intestinal ulcers? **Yes/No**
23. Digestive problems? **Yes/No**
24. Arthritis? If so what type and where in the body? **Yes/No**
25. Artificial joints (knee or hip and when)? _____ **Yes/No**
26. Allergies and sensitivities? **Yes/No**
27. Cancer or tumour? If so what type? _____ **Yes/No**
28. Radiation? **Yes/No**
29. Chemotherapy? **Yes/No**
30. AIDS or positive for HIV? **Yes/No**
31. Cold sores? **Yes/No**
32. COVID 19? **Yes/No**
33. Sexually Transmitted Infections? (Syphilis, gonorrhoea etc.) **Yes/No**
34. Fainting spells? **Yes/No**
35. Epilepsy or convulsions? **Yes/No**
36. Nervous disorders e.g. Parkinson's disease? **Yes/No**
37. Psychiatric disorders? **Yes/No**
38. Trauma to face or head? **Yes/No**
39. Frequent headaches? **Yes/No**
40. Vision problems? e.g. glaucoma **Yes/No**
41. Cosmetic surgery? **Yes/No**
42. Sinus problems? **Yes/No**
43. Hay fever? **Yes/No**
44. Drug addiction? **Yes/No**
45. Cortisone medication? **Yes/No**
46. Sickle cell disease? **Yes/No**
47. Scarlet fever? **Yes/No**

Are there any problems which have not been listed above? **Yes/No**
If yes please provide details_____
Is there anything in the questionnaire which you did not understand? **Yes/No**

PATIENT CERTIFICATION:
I, the undersigned certify that all the above medical information is true to the best of my knowledge and I have not omitted any pertinent information.

Signature _____ *Date* _____
Signature of parent or guardian (if under 19) _____

Dentist's Comments:_____
_____
_____
_____

Update:_____
_____
_____

*Dentist Signature*_____ *Date*_____