Family Dental

Medical History

22 Sir Winston Churchill Avenue, St. Albert, AB T8N 1B4
Phone: 780-458-1991 • Fax: 780-459-8284
info@family-dental.ca • www.family-dental.ca

Patient Name	**Medical Alert** *(Office Use Only)*

Address ______ City ______ Postal Code ______

Phone (home) ______ (cell) ______ Sex M ☐ F ☐ Age ______ Birth Date ___ / ___ / ___ (month / day / year)

Adult Patient

Occupation ______

Employer ______

Phone (work) ______

Email ______

Marital Status M ☐ S ☐ W ☐ D ☐

Dental Insurance No ☐ Yes ☐ ______

Child Patient

Mother's Name ______

Employer ______ Phone (work) ______

Father's Name ______

Employer ______ Phone (work) ______

Person responsible for account ______

AHC# ______

How did you find about our office? Friend ☐ Name ______ Phonebook (Yellow Pages) ☐ (St. Albert Directory) ☐

Newspaper ☐ Flyer ☐ Internet ☐ Website ______ Other ☐ Please Specify ______

What is your preferred method of contact? Phone ☐ Text ☐ Email ☐

1. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If yes, for what? ______

Physician's name ______ Phone ______

2. Have you taken any medication or drugs now or during the past two years? Yes ☐ No ☐

If yes, please list the name and dosage ______

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes ☐ No ☐

If yes, please list ______

4. Have you been hospitalized in the past five years? Yes ☐ No ☐

5. Indicate which of the following you have had, or presently have

Condition	Yes	No
Heart (Surgery, Disease, Attack)	☐	☐
Chest Pain	☐	☐
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Artificial Heart Valve	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Peacemaker	☐	☐
Rheumatic Fever	☐	☐
Arthritis / Rheumatism	☐	☐
Cortisone Medicine	☐	☐
Swollen Ankles	☐	☐
Stroke	☐	☐
Diet (Special / Restricted)	☐	☐
Artificial Joints (hip, knee etc.)	☐	☐
Kidney Trouble	☐	☐
Latex Sensitivity	☐	☐
Stomach Ulcers	☐	☐
Diabetes	☐	☐
Thyroid Problems	☐	☐
Glaucoma	☐	☐
Emphysema	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Hay Fever	☐	☐
Allergies or Hives	☐	☐
Sinus Trouble	☐	☐
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Tumors	☐	☐
Do You Smoke	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Yellow Jaundice	☐	☐
Venereal Disease	☐	☐
A.I.D.S.	☐	☐
H.I.V. Positive	☐	☐
Cold Sores / Fever Blisters	☐	☐
Blood Transfusion	☐	☐
Hemophilia	☐	☐
Sickle Cell Disease	☐	☐
Bruise Easily	☐	☐
Neurological Disorders	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizzy Spells	☐	☐
Nervous / Anxious	☐	☐
Psychiatric / Psychological Care	☐	☐

6. Do you have, or have you had any disease, or problem not listed? Yes ☐ No ☐

If yes, please list ______

7. Women Are you: **Pregnant?** Yes ___ Months No ☐ **Nursing?** Yes ☐ No ☐ **Taking Birth Control Pills** Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature ______ Date ___ / ___ / ___ (month / day / year)