

Patient Medical Information

ENDLESS SMILES DENTAL HYGIENE

Title _____	First Name _____	Surname _____
Health Card Number _____	Email _____	
Date of birth _____	Occupation _____	Employer _____
Address _____	Referred By _____	
		Postal Code _____
Tel Contact Home: _____	Work: _____	
Mobile: _____		
Emergency Contact _____	Emergency Contact Number _____	

Are you being treated for any medical condition at the present or or have you been treated within the last year? Yes No Not Sure

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year? Yes No Not Sure

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes No Not Sure

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below: Yes No Not Sure

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes No Not Sure

If yes, please explain _____

Do you have or have you ever had asthma? Yes No Not Sure

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No Not Sure

Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure

Which type of hepatitis? _____

Do you have a prosthetic or artificial joint? Yes No Not Sure

If yes, please explain _____

Do you have bleeding problem or bleeding disorder? Yes No Not Sure

If yes, please explain _____

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Have you ever been hospitalized for any illness or operations?

Yes No Not Sure

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes No Not Sure

Do you have or have you ever had any of the following? Please Check

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Digestive Disorders / Acid Reflux | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug / Alcohol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Lupus | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraine | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis Medications (e.g. Fosamax, Actonel) | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Parkinsons Disease | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Hodgkins Disease | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Tuberculosis |

Are there any conditions or disease not listed above that you have or have had?

Yes No Not Sure

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes No Not Sure

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes No Not Sure

Are you nervous during dental treatment?

Yes No Not Sure

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Do you have a dry mouth?

Do you have any eye problems?

Require corrective lenses?

Glaucoma

Do you have any ear or hearing problems?

Do you wear hearing aids?

Sleep Disorders?

Are you or could you be pregnant?

If yes, expected delivery date:

Are you taking hormone replacement therapy?

Are you breastfeeding?

Hygienist _____

Tel _____

Address _____

The Information I have given above is true to the best of my knowledge.

Patient Signature _____

Date _____
