SYDENHAM
FAMILY DENTISTRY

**CONFIDENTIAL HEALTH HISTORY**

NAME:_____

PARENTS ☐ SPOUSE ☐ _____

ADDRESS:_____
Street City Postal Code

PHONE: Home _____ Cell _____ Business _____

EMAIL: _____ DATE OF BIRTH: _____
DD/MM/YY

EMPLOYER:_____ SCHOOL:_____

Who referred you to our office?_____

FAMILY DOCTOR_____ HEALTH CARD #_____

EMERGENCY CONTACT:_____ PHONE: _____

RELATIONSHIP OF CONTACT:_____

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**DENTAL INSURANCE:** YES ☐ NO ☐

SUBSCRIBERS NAME:_____ DOB:_____
DD/MM/YY

EMPLOYER:_____ INSURANCE CO. NAME:_____

POLICY #_____ ID/CONTRACT #_____

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**MEDICAL HISTORY:**

Are you currently receiving medical care?_____ If yes, nature of care:_____

Have you ever been hospitalized?_____ If yes, explain:_____

_____

Do you have any allergies? _____ If yes, explain:_____

_____

Are you allergic to any medication or drugs? _____ If yes, explain:_____

_____

## CONFIDENTIAL HEALTH HISTORY

Have you ever had any ill effects or reaction to freezing (local anesthetic) in your mouth?_____

If yes, explain:_____

Have you ever had abnormal bleeding after surgery, injury or dental extractions? _____

Have you taken cortisone or steroids? _____ If yes, when and for how long? _____

**CURRENT MEDICATIONS:** List any medications and/or supplements (herbal remedies).

1._____Dosage:_____Reason:_____

2._____Dosage:_____Reason:_____

3._____Dosage:_____Reason:_____

4._____Dosage:_____Reason:_____

Do you have or have you ever had any of the following: (please circle or check)

| | | | |
|---|---|---|---|
| Heart Trouble | Epilepsy | Mental/Nervous Disease | Joint Replacement |
| High Blood Pressure | Kidney Disease | Cancer | Stroke |
| Lung Disease | Liver Disease | Radiation Therapy | Heart attack |
| Asthma | Hepatitis | Chemotherapy | Previous Surgery |
| Diabetes | Tuberculosis | Osteoporosis | Dental Anxiety |
| Blood Disorders | Gastrointestinal Disease | Venereal Diseases | Smoking/Vaping |
| Anemia | Thyroid Condition | HIV infection | Recreational Drugs |

Please explain any of the above selected conditions:_____

_____

_____

WOMEN:

Are you pregnant?_____ Nursing?_____Planning a pregnancy in the near future?_____

**Is there anything else the dentist should know regarding your medical/health history?**

_____

_____

Date:_____ Signature:_____