WEST MALL DENTAL GROUP
FAMILY DENTISTRY

NEW PATIENT FORM

MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

1. Is the patient in good health? ..... Y ☐ N ☐ O ☐
   If no, please provide details:

2. Has there been any change in the patient's general health or weight in the past year? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

3. Is the patient currently being treated for any medical condition or has he/she been treated in the last year?
   ..... Y ☐ N ☐ O ☐
   If yes, please explain:

4. When was the last time the patient had a medical examination? _____
   Were any problems identified? ..... Y ☐ N ☐ O ☐
   If yes, please explain:

5. Has the patient ever been hospitalized for any illnesses or operations? ..... Y ☐ N ☐ O ☐
   If yes, please provide details:

6. Is the patient taking any medications, non-prescription drugs or herbal supplements of any kind? Y ☐ N ☐ O ☐
   If yes, please list and provide reason for taking:

7. Does the patient have any allergies? ..... Y ☐ N ☐ O ☐
   If yes, please list using the categories below:
   Medications _____
   Latex/rubber products _____
   Other (e.g. hay fever, foods) _____

8. Has the patient had a peculiar or adverse reaction to any medicines, injections or dental local anaesthetic?
   ..... Y ☐ N ☐ O ☐
   If yes, please explain:

9. Has the patient experienced any new symptoms such as a cough or illness since recent travel or otherwise? Y ☐ N ☐ O ☐
   If yes, please explain:

10. Does the patient have or has the patient ever had a replacement or a 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?
    ..... Y ☐ N ☐ O ☐
    If yes, please explain:

11. Has the patient ever been advised to take antibiotic pre-medication prior to dental treatment? .. Y ☐ N ☐ O ☐
    If yes, please explain:

MEDICAL HISTORY CONTINUED ON NEXT PAGE

MEDICAL HISTORY (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

12. Does the patient have a prosthetic or artificial joint? ..... Y ☐ N ☐ O ☐
If yes, please explain:

13. Does the patient have any conditions or is the patient undergoing any therapies that could affect his/her immune system?
(E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)..... Y ☐ N ☐ O ☐
If yes, please explain:

14. Has the patient ever had hepatitis, jaundice, liver disease, or gastrointestinal disorders?..... Y ☐ N ☐ O ☐
If yes, please explain:

15. Does the patient have a bleeding problem, bleeding disorder or bruising tendency?..... Y ☐ N ☐ O ☐
If yes, please explain:

16. Does the patient have any or has the patient ever had any of the following (circle all that apply):

a. Fainting / Dizzy spells
b. Eating disorder
c. Stroke
d. Rheumatic fever
e. Mitral valve prolapse
f. Heart problems, murmur
g. Asthma or Emphysema
h. Pacemaker
i. Lung disease
j. Tuberculosis
k. Cancer
l. Steroid therapy
m. Diabetes
n. Stomach ulcers
o. High blood pressure
p. Arthritis / Rheumatism
q. Seizures / Epilepsy
r. Kidney disease
s. Thyroid disease
t. High / Low blood pressure
u. Hyper / Hypoglycemia
v. Mental or Nervous disorder
w. Circulatory problems
x. Blood transfusion
y. Other communicable disease / Transmissible infection

17. Are there any conditions or diseases not listed above that the patient has or has had?..... Y ☐ N ☐ O ☐
If yes, please provide details:

18. Is there any additional information related to the patient's health that has not been addressed above?

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

(Reviewed By Dentist): DATE

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FAMILY DENTISTRY

MEDICAL HISTORY CONTINUED (PLEASE SELECT YES, NO, OTHER/UNSURE TO EACH QUESTION)

21. Have you developed a fever or chills in the last 24 hours? ..... Y ☐ N ☐ O ☐

22. Have you had a recent and sudden onset of diarrhea? ..... Y ☐ N ☐ O ☐

23. Have you experienced a new undiagnosed rash, lesion or break in your skin? ..... Y ☐ N ☐ O ☐

24. Have you had a recent exposure to communicable infectious disease?
(E.g. measles, chicken pox or tuberculosis?) ..... Y ☐ N ☐ O ☐

25. Have you recently received antimicrobial therapy? ..... Y ☐ N ☐ O ☐
If so, for what reason?

_____

_____

27. Have you recently travelled to areas where endemic diseases are present? ..... Y ☐ N ☐ O ☐

28. Are your immunizations up to date? ..... Y ☐ N ☐ O ☐

30. Is there any additional information related to your health that has not been addressed above?
If so, please advise:

_____

_____ _____

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

_____ _____

(Reviewed By Dentist): DATE