Signature SMILES
Suite 201, 103 3 Avenue S.W.
High River, Alberta T1V 1M5
ph (403) 603-3364 • fx (403) 603-3286

Medical History

All information is confidential.

Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following pertinent questions.

Patient Name:_____ Date of Birth:_____
Physician's Name:_____ Phone #_____

Are you presently, or have you recently been under the care of a physician for any condition or serious ailment?
NO YES Please explain:_____
Have you ever had a serious illness or accident requiring hospitalization or extensive medical care?
NO YES If yes, please specify:_____

Do you use any prescription or non-prescription medicine? If so, please list below.
Drug_____ Reason_____ Drug_____ Reason_____
Drug_____ Reason_____ Drug_____ Reason_____

Have you ever experienced any unusual or allergic reaction to any of the following? (please circle)
Local anaesthesia Sulfa Drugs Latex/Rubber Aspirin(ASA) Erythromycin
Barbiturates Penicillin Metal(nickel) Codeine

Do you have or have you ever had any of the following? (Please circle those applicable)

Fainting or dizziness	HIV positive/testing	Back Problems
Malignant hyperthermia	Mental or nervous disorder	Scarlet or Rheumatic fever
Heart attack/Stroke	Venereal disease/Herpes	Cortisone/Steroid therapy
Artificial Joint Replacement	Tumors	Kidney/liver disease
High/Low Blood pressure	Thyroid disease	Hepatitis A,B or C
Arthritis or Rheumatism	Diabetes	Jaundice
Stomach/intestinal problems	Cancer/Radiation/Chemotherapy	Organ/Medical implants
Sinus trouble	Hyper/hypo glycemia	Convulsions
Epilepsy or Seizures	Drug/Alcohol addiction	Mitral Valve Prolapse
Heart murmur	Blood disorder/anemia	frequent severe Headaches

Do you have any disease, condition or problem that you think the doctor should know about? NO YES

_____

Have you ever had any injury, surgery or x-ray therapy to your face or jaws? NO YES

Women only: (please circle) Taking Birth Control pills Nursing Pregnant what month?_____

PATIENT (GUARDIAN) CONSENT AND APPROVAL

I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Patient (parent , guardian) Signature_____ **Date(d/m/y)**_____