Birchland DENTAL CLINIC
5118 51 Ave, Ponoka, AB T4J 1R5, Canada
403.907.9666
www.birchlanddental.ca

Medical History

First Name		Last Name		Guardian Name if minor	
Birthday		Age		☐ Male ☐ Female ☐ Prefer not to say	
Address					
City		Province		Postal Code	
Home Phone		Cell Phone		Work Phone	
Email					

Chief Concern: _____

What is your estimate of your general health? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Do you have or have you ever had

1. Hospitalization for illness or injury ☐ **Yes** ☐ **No** If yes, Please provide details: _____
2. An Allergic reaction to ☐ **aspirin** ☐ **ibuprofen** ☐ **acetaminophen** ☐ **codeine** ☐ **penicillin** ☐ **tetracycline** ☐ **local anesthetic** ☐ **metals (nickel, gold, silver)** ☐ **fluoride** ☐ **sulfa** ☐ **erythromycin** ☐ **latex** ☐ **other** _____
3. Do you have a history of any of the following that may require antibiotic coverage?
   - Prosthetic cardiac valves, including transcatheter implanted prostheses & homograft's. ☐ **Yes** ☐ **No**
   - Previous infective endocarditis. ☐ **Yes** ☐ **No**
   - Prosthetic material used for cardiac valve repair, such as annuloplasty rings & chords. ☐ **Yes** ☐ **No**
   - Unrepaired cyanotic congenital heart disease or repaired congenital heart disease, with residual shunts or valvular regurgitation at the site of or adjacent to the site of a prosthetic patch or prosthetic device. ☐ **Yes** ☐ **No**
   - A cardiac transplant with valve regurgitation due to a structurally abnormal valve. ☐ **Yes** ☐ **No**
4. Joint Replacement ☐ **Yes** ☐ **No** If yes what joint _____ When? _____
5. High blood pressure ☐ **Yes** ☐ **No** or Low blood pressure ☐ **Yes** ☐ **No**
6. A stroke within the last 6 months ☐ **Yes** ☐ **No**
7. Taking blood thinners ☐ **Coumadin** ☐ **Plavix** ☐ **Adult Aspirin** ☐ **Yes** ☐ **No** If yes, INR #= _____
8. Prolonged bleeding due to a slight cut ☐ **Yes** ☐ **No**
9. Diabetes ☐ **Yes** ☐ **No** If yes, HbA1c= _____
10. Heart problems (heart attack), or cardiac stent within the last six months ☐ **Yes** ☐ **No**
11. Female only:
    - Taking birth control pills ☐ **Yes** ☐ **No**
    - Are you pregnant? ☐ **Yes** ☐ **No** If yes, how many weeks? _____
12. Taking medication for weight management (i.e. fen-phen) ☐ **Yes** ☐ **No**

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Print name: _____ Signature: _____ Date: _____