Cloverdale Dental Group
Family & Cosmetic Dentistry

250 The East Mall, Suite 211
Etobicoke, ON M9B 3Y8

416.236.2304

MEDICAL HISTORY: Please Check

Are you under a physician's care now? Why? Who? _____Phone#_____ ☐ Yes ☐ No
Have you ever been hospitalized or had a major operation? Discuss _____ ☐ Yes ☐ No
Have you ever had a serious injury to the head or neck? Discuss _____ ☐ Yes ☐ No
Are you taking any medications, pills or drugs? What? _____ ☐ Yes ☐ No
Are you on a special diet? Discuss _____ ☐ Yes ☐ No
Are you allergic to any medications or substances? Please check box below_____ ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex rubber ☐ Other_____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

If yes to any of the starred* conditions, please call prior to your appointment... Pre-medication may be required.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Irregular Heartbeat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐
Angina / Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Treatment	☐	☐
Heart Attack/ Failure	☐	☐	Hemophilia	☐	☐	Chemotherapy	☐	☐
Congenital Heart disorder	☐	☐	Leukemia	☐	☐	Stomach/ Intestinal Disease	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (infectious)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐
Yellow Jaundice	☐	☐	Cold Sores	☐	☐	Thyroid Disease	☐	☐
Kidney Problems	☐	☐	Fever Blisters	☐	☐	Parathyroid disease	☐	☐
Renal Dialysis	☐	☐	Herpes	☐	☐	Arthritis/ Gout	☐	☐
Venereal Disease	☐	☐	Stroke	☐	☐	Rheumatism	☐	☐
AIDS	☐	☐	Convulsions	☐	☐	Pain in Jaw Joints	☐	☐
HIV Positive	☐	☐	Epilepsy or Seizures	☐	☐	Cortisone Medicine	☐	☐
Genital Herpes	☐	☐	Fainting or Dizziness	☐	☐	Glaucoma	☐	☐
Drug Addiction	☐	☐	Nervousness	☐	☐	Tumors or Growths	☐	☐
Allergies (Medicines)	☐	☐	Psychiatric Care	☐	☐	Alzheimer's Disease	☐	☐
Allergies (Pollen or Dust)	☐	☐	Hives or Rash	☐	☐		☐	☐

Have you ever had any other serious illness not checked above? Discuss_____ ☐ Yes ☐ No

Do you wish to talk to the dentist privately about any problem? _____ ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X_____**Date**_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor_____ **Date**_____

Significant Findings _____
_____

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CLEAR FORM

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