Patient Intake & Medical History

NAME:MR/MISS/MRS/MS/DR _____ Date of BIRTH: _____ ADDRESS(HM): _____ POSTAL CODE: _____ PHONE NUMBER: _____ OCCUPATION: _____ ADDRESS (BUSINESS): _____ WHO REFERRED YOU TO OUR OFFICE:	IN CASE OF EMERGENCY, WE SHOULD NOTIFY: NAME: _____ RELATIONSHIP: _____ PHONE NUMBER: _____ NAME OF FAMILY DOCTOR: _____ ADDRESS: _____ POSTAL CODE: _____ NAME OF MEDICAL SPECIALIST: _____ PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best dental care. All information is strictly private, and is protected by doctor-patient confidentially. The dentist will review the questions and explain any that you don't understand. Please fill in the entire form.

Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ☐ YES ☐ NO ☐ NOTSURE/MAYBE

_____

When was you last medical checkup? _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

_____ ☐ YES ☐ NO ☐ NOTSURE/MAYBE

Has there been any changes in your general health in the past year? If yes, please explain.
_____ ☐ YES ☐ NO ☐ NOTSURE/MAYBE

Do you have any allergies? If yes, use the categories below. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Medications: _____

Latex/Rubber Products: _____

Other (Hay Fever, Food): _____

Do you have/have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.
_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have/have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have / have you ever had a replacement or repair of a heart valve, infection of the heart (infective endocarditis), a heart condition from birth (congenital hearty disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have any conditions or therapies that could affect your immune system? Specify.
(Leukemia, AIDS, HIV infection, Radiotherapy, chemotherapy)

_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Have you ever been hospitalized for any illnesses or operation? If yes, please explain.

_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you have/have you ever had any of the following?

☐ Chest pain	☐ Rheumatic Fever	☐ Pacemaker	☐ Drug/Alcohol dependency
☐ Mitral Valve Prolapse	☐ Lung Disease	☐ Arthritis O Stroke	☐ Heart Murmur
☐ Tuberculosis	☐ Seizures	☐ Heart Attack	☐ Shortness of Breath
☐ Stomach Ulcer	☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease
☐ Diabetes	☐ Osteoporosis Medications		

Other:_____

Are there any diseases or medical problems that run in your family? If yes, please list.

_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

For Women Only: Are you breastfeeding or pregnant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

If Pregnant, what is the expected delivery date? _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

DENTIST SIGNATURE: _____

DATE: _____

Oxford Dental

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SUBMIT FORM