BDS Medical & Dental History Update Form

Patient Full Legal Name:

Patient Preferred First Name:

Would you consider yourself to be in;

☐ Excellent health ☐ Good health ☐ Fair health ☐ Poor health

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's Name, Address and Phone #:

OHIP #

Nearest Pharmacy Name, Address and Phone #

Are you currently being treated for any medical condition? Yes ☐ No ☐

If yes, please describe. (If you take any prescription medications – you ARE being treated for a medical condition – please specify)

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

Yes ☐ No ☐

If yes, please list them (including dosages and frequency taken). (Please also list any inhalers, topical medications, prescription eye drops, etc.)

Do you have any allergies?

☐ None ☐ Medications

☐ Latex/Rubber products ☐ Other (eg. hay fever, seasonal/environmental foods)

If yes, please list them below, and associated reaction:

Have you ever had a peculiar or adverse reaction to any medicines or injections?

☐ Yes ☐ No ☐ Not Sure/Maybe

If yes, please explain.

Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Never

If yes, for how many years and how many packs a day?

If no, when did you quit?

How many years did you smoke overall?

Do you have or have you ever had Asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

Do you have or have you ever had any heart or blood pressure problems?

☐ Yes ☐ No ☐ Not Sure/Maybe

What is your Blood Pressure (Typically)?

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), a heart condition from birth (e.g. congenital heart disease) or heart transplant? ☐ Yes ☐ No ☐ Not Sure/Maybe

Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe

If yes, please specify, and include date of surgery.

Do you require pre-medication prior to dental treatment?

☐ Yes ☐ No

Type of Pre-medication:

Do you have or have you ever had any of the following? Please check.

☐ Chest pain/Angina	☐ Elevated Cholesterol	☐ Cancer
☐ Heart attack	☐ Heart murmur	☐ Bleeding disorder
☐ Stroke, TIA	☐ Rheumatic fever	☐ Liver disease
☐ Acid Reflux	☐ Mitral valve prolapse	☐ Jaundice
	☐ Tuberculosis	☐ Hepatitis A, B, C

☐ Pacemaker
☐ Lung disease
☐ Shortness of breath
☐ Stomach ulcers
☐ Arthritis

☐ Steroid therapy
☐ Diabetes
☐ Thyroid disease
☐ Drug/alcohol/ cannabis use or dependency

☐ Seizures (epilepsy)
☐ kidney disease
☐ Osteoporosis medications

If you have Diabetes, when was your most recent A1C Test completed?

What was your most recent A1C Test result?

What is your typical A1C Test result?

Are there any conditions or diseases not listed previously that you have or have had?
☐ Yes ☐ No ☐ Not sure/Maybe

If yes, please explain (include dates of diagnosis)

Do you have any conditions or therapies that could affect your immune system (e.g., leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/Maybe

If yes please explain:

Have you ever been hospitalized for any illness or operations? ☐ Yes ☐ No

If yes, please explain and provide the date/year:

Are there any diseases or medical problems that run in your family (eg. diabetes, cancer or heart disease)? ☐ Yes ☐ No ☐ Not sure/Maybe

If yes, please specify:

Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure/Maybe

Are you breastfeeding or pregnant? ☐ Yes ☐ No ☐ Not sure/Maybe

If pregnant, what is the expected delivery date?

Do you identify as a patient with a disability? ☐ Yes ☐ No

If yes, how may we best assist you in our dental practice?

Authorization

☐ *To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.
The **confirmation checkbox** is required

☐ *I hereby certify that I have been provided with and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
The **confirmation checkbox** is required

☐ *I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
The **confirmation checkbox** is required

☐ *I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.
The **confirmation checkbox** is required

☐ *I understand that Barrie Dental Specialists is a fee for service dental specialty practice and I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).
The **confirmation checkbox** is required

Signature: Response Date: