7575 Market Crossing
Burnaby, B.C. V5J OA3
Tel :604.433.7444

Medical History – 1

Please Circle
Are you having any pain or discomfort at this time?...Yes / No
Have you been a patient in the hospital during the previous two years?.............. ......Yes / No
Are you currently under the care of a physician?.. Yes / No
If yes:
Physician's Name: Specialty:
Physician's Address: Telephone #: (   ) -
Are you taking any medication at the present time?... Yes / No
If yes, please list the medications and their daily dosages:

Are there any medications that you should be taking, but are not taking? ....Yes / No
If yes, please explain:

Are you **allergic** to (i. e. itching, rash, swelling, etc.) or have you ever been made sick by:
[If yes, please **circle**]

Penicillin? Aspirin? Codeine? Sulfa? Acetaminophen? Lidocaine? Ibuprofen?
Other? please explain:

Have you ever had any excessive bleeding requiring special treatment?................. Yes / No
Do you currently smoke cigarettes, pipes, or cigars?... Yes / No
If yes, would you consider a smoking cessation program?....................................... Yes / No
Do you chew smokeless tobacco?...Yes / No
Do you consume more than three alcoholic beverages each day?............................. Yes / No
Women: Failure to disclose that you are taking oral contraceptives (when combined with certain antibiotic therapies) may result in the contraceptive method being rendered ineffective.
WOMEN: Are you pregnant?.. Yes / No
If yes, when are you expecting?

I understand that several substances, including, but not limited to, anabolic steroids, cocaine, excessive alcohol, etc., may have dangerous, and even fatal effects, when combined with dental anesthetics. I will disclose any potentially significant information to Smile Dental Group.

Date Patient's Name...

Patient's Signature...