

# Integrity Dental

A division of Harold F.G. Elke prof. corp.

ALERTS

PREMEDS



PATIENTS LAST NAME	FIRST NAME	INITIAL(S) MARITAL STATUS
BILLING NAME	BIRTHDATE D / M / Y SEX	
BILLING ADDRESS	PHONE 1	
CITY	POSTAL CODE	PHONE 2
EMAIL	<b>REFERRED BY</b>	
EMPLOYER	WORK PHONE	
DENTAL DECISIONS MADE BY: <input type="checkbox"/> Self <input type="checkbox"/> Guardian <input type="checkbox"/> Trustee	GUARDIAN/TRUSTEE NAME	GUARDIAN PHONE
DENTAL INSURANCE PLAN: YES / NO	PHYSICIAN NAME	
	CLINIC	PHONE

## MEDICAL HISTORY

Do you have a current medical problem? No  Yes  If "yes" indicate what problem:

\_\_\_\_\_

**1. Have you been hospitalized or had a serious illness within the last 5 years?** Yes  No

If yes, why/what: \_\_\_\_\_

**2. Do you have or have you had any of the following:**

Heart or circulatory

- heart failure
- heart attack
- heart murmur
- congenital defect
- artificial valve
- pacemaker
- stroke
- rheumatic fever
- angina
- high blood pressure
- shortness of breath
- other \_\_\_\_\_

Lung or breathing

- asthma
  - tuberculosis
  - allergies
  - sinus trouble
  - other \_\_\_\_\_
- Contagious diseases
- cold sores
  - HIV / AIDS
  - venereal disease
  - hepatitis
  - other \_\_\_\_\_

Nervous or brain

- migraines
  - epilepsy
  - seizures
  - fainting, dizzy spells
  - brain injury
  - multiple sclerosis
  - other \_\_\_\_\_
- Blood disorders
- hemophilia
  - sickle cell anemia
  - leukemia
  - other \_\_\_\_\_

Other

- thyroid disease
- glaucoma
- kidney disease
- artificial joint
- diabetes
- ulcers
- tumors
- arthritis
- jaundice or liver disease
- steroid therapy
- diet pill therapy
- drug/alcohol dependency
- other \_\_\_\_\_

**3. Are you allergic to, or have you been told not to take:** \_\_\_\_\_

- antibiotics \_\_\_\_\_
- painkillers \_\_\_\_\_
- aspirin \_\_\_\_\_
- local anesthetics \_\_\_\_\_
- sedatives \_\_\_\_\_
- latex materials \_\_\_\_\_
- other: \_\_\_\_\_

**4. Are you:**

- on a prescribed diet
- taking herbal supplements
- a smoker
- an ex-smoker
- nursing
- pregnant
- expected delivery date: \_\_\_\_\_

**5. Are you presently taking any medication?** Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. Do you require pre-medication for Dental treatment?** Yes  No

If yes, what: \_\_\_\_\_

**7. Is there anything else we should be aware of regarding your health? Has there been any change in your general health in the past year?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

