KOOTENAY LAKE DENTAL

HEALTH HISTORY FORM

PATIENT NAME		EMAIL	
DATE OF BIRTH		PHONE	
PERSONAL HEALTH NUMBER		ADDRESS	
PARENT / GUARDIAN (if minor)			

FAMILY PHYSICIAN NAME	
MEDICATIONS (PLEEASE LIST)	
ALLERGIES (PLEEASE LIST)	

PLEASE ANSWER IF ANY OF THE BELOW APPLY

	YES	NO	COMMENT		YES	NO	COMMENT
AUTOIMMUNE DISEASE	☐	☐		DIABETES	☐	☐	
CHEST PAIN /ANGINA	☐	☐		KIDNEY DISEASE	☐	☐	
HEART ATTACK	☐	☐		STROKE	☐	☐	
HEART MURMUR	☐	☐		SEIZURES OR EPILEPSY	☐	☐	
HIGH BLOOD PRESSURE	☐	☐		OSTEOPOROSIS OR BISPHOSPONATE MEDICATIONS	☐	☐	
PROSTHETIC HEART VALVE	☐	☐		ARTHRITIS OR PROSTHETIC JOINTS	☐	☐	
PACEMAKER	☐	☐		BLEEDING DISORDERS AND BLEEDING PROBLEMS	☐	☐	
SLEEP APNEA	☐	☐		HIV/AIDS	☐	☐	
ASTHMA OR SHORTNESS OF BREATH	☐	☐		HEPATITIS / JAUNICE / LIVER DISEASE	☐	☐	
LUNG DISEASE (COPD , EMPHYSEMA OR OTHER)	☐	☐		SMOKING OR CHEW TOBACCO	☐	☐	
TUBERCULOSIS	☐	☐		DRUG OR ALCOHOL DEPENDENCY	☐	☐	
STEROID THERAPY	☐	☐		DEPRESSION/ANXIETY OR OTHER PSYCHIATRIC DISORDER	☐	☐	
CANCER	☐	☐		STOMACH ULCERS OR ACID REFLUX	☐	☐	
CHEMOTHERAPY/ RADIATION	☐	☐		PROBLEMS WITH LOCAL ANESTHETIC	☐	☐	
NEED ANTIBIOTICS FOR DENTAL TREATMENT	☐	☐		FOR WOMAN : ARE YOU OR COULD YOU BE PREGNANT	☐	☐	

ANY OTHER CONDITIONS NOT MENTIONED HERE THAT WE SHOULD BE AWARE OF :	

I ACKNOWLEDGE THE ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND WILL UPDATE KOOTENAY LAKE DENTAL CLINIC SHOULD THERE BE ANY CHANGES TO MY HEALTH INFORMATION

PATIENT OR GUARDIAN SIGNATURE		DATE	

PRACTITIONER SIGNATURE	