DAWSON DENTAL CENTRE

Medical History Update

		Preferred Name:	
Address:		Apt/Unit#:	
City:	Province:	Postal Code:	
Home Phone:	Cell:	Work:	ext:
Date of Birth:	(mm/dd/yyyy)	E-mail address:	
Family Physician:			
Pharmacy Name:			
		ncluding appointment reminders? 🗖 `	
May we send you text message appo		□ Yes □ No	ies 🗆 NO
You have the option to withdraw your conse		2 100 2 110	
Please check any PAST or PRESENT r	•		
□ Heart condition	□ HIV positive/AIDS	□ Cancer - type:	□ Vision Impairment
□ Angina	□ Anemia	Date	☐ Hearing impairment
□ Heart surgery/procedures	□ Blood disorders	Radiation:	□ TMJ (jaw joint) concerns
□ Heart attack	□ Hepatitis A/B/C	Chemotherapy:	□ Physical impairment
□ Stroke/T.I.A	□ Hemophilia	Surgery	□ Arthritis
□ Heart murmur	□ Excessive bleeding/br		□ Osteoporosis
□ Mitral valve prolapse	□ Immunedeficiencies	□ Respiratory conditions	□ Long-term Actonel/Fosomax us
□ Congenital heart disease	□ Eating disorder	□ Tuberculosis	□ Epilepsy/seizures
□ Infective Endocarditis	□ Lupus	□ Snoring/sleep apnea	□ Cognitive impairment
□ Pacemaker	□ Thyroid disease	□ Dizziness/fainting	□ Depression
□ High blood pressure	□ Kidney disease	□ HPV	□ Anxiety
□ Low blood pressure	□ Liver disease	□ Herpes/cold sores	□ Mental health issues
□ General Anesthetic complications	□ Joint replacement	□ Ulcers/acid reflux	□ Drug/alcohol dependency
□ Diabetes: Type I or II	joint	Intestinal/stomach problems	□ Tobacco Use
□ Hypoglycemia	date	□ Above average weight gain/l	oss Other
	Food: Environ	ment:	
Have you had any surgery in the past Explain:	Possibly Yes tor coming up in the near		
Have you had any surgery in the past Explain: Is there anything else to report about	Possibly \(\text{Yes} \) \(\text{t or coming up in the near} \) \(\text{t your health not listed ab} \)	future: No - Yes -	ATIONS:
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