North York
ORAL SURGERY & IMPLANT CENTRE

Medical History

Name____**Date**:_________________________

Do you see a family doctor regularly?
Yes ☐ No ☐

Do you currently or take any medications?
Yes ☐ No ☐

-If yes, please list on next page.

Are you currently taking any vitamin or herbal supplements?
Yes ☐ No ☐

-If yes, please list on next page.

Do you have any allergies, especially to medicine?
Yes ☐ No ☐

-If yes, please list on next page.

Have you ever taken a drug for the treatment of osteoporosis in the last 5 years?
Yes ☐ No ☐

Do you follow a special diet?
Yes ☐ No ☐

Do any diseases run in your family?
Yes ☐ No ☐

-If yes, please list on next page.

Women: Are you pregnant or trying to get pregnant?
Yes ☐ No ☐

Do you bruise easily?
Yes ☐ No ☐

Do you ever get fluttering or pounding feeling in your chest?
Yes ☐ No ☐

Do you ever get chest pain?
Yes ☐ No ☐

Do your ankles, feet or hands swell?
Yes ☐ No ☐

Do you get short of breath after climbing two flights of stairs?
Yes ☐ No ☐

Do you have difficulty breathing through your nose?
Yes ☐ No ☐

Have you ever had an illness that resulted in a long absence from school or work?
Yes ☐ No ☐

Have you ever had an operation?
Yes ☐ No ☐

-If yes, please list on next page.

Have you ever been in a hospital overnight?
Yes ☐ No ☐

Have you ever had non-surgical anesthesia/sedation such as a colonoscopy?
Yes ☐ No ☐

Have you ever had an unpleasant experience with sedation or anesthesia?
Yes ☐ No ☐

Do you get motion sickness in cars or planes?
Yes ☐ No ☐

Do you currently smoke?
Yes ☐ No ☐

-If yes, how much?

Do you Vape?
Yes ☐ No ☐

Do you use any nicotine products such as gum or patches?
Yes ☐ No ☐

Do you drink alcohol?
Yes ☐ No ☐

-If yes, how much?

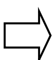
Do you take any recreational drugs?
Yes ☐ No ☐

-If yes, please list on next page.

Do you wear contact lenses?
Yes ☐ No ☐

Is there anything else you would like to tell us?
Yes ☐ No ☐

-If yes, please let the doctor know.

PLEASE TURN OVER 

Have you ever had any of the following?

- ☐ Asthma
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Arthritis/ Gout
- ☐ AIDS/ HIV
- ☐ Bronchitis
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cortisone/ Steroid
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy/ Seizures
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Disorder
- ☐ Heart Pacemaker
- ☐ Hepatitis B / C
- ☐ Hypertension
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Malignant Hyperthermia
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Venereal Disease

Current Medications, Allergies and Notes

Medications:

Allergies:

Notes/Misc:

Medical History Update

	Date:	Date:	Date:	Date:
Have there been anychanges in yourmedical history?				
Have you had anyserious illnesses?				
Are you taking anynew medication?				
Are you under the care of a physician?				
Women: Are you pregnant?				

I understand the preceding questions and I have answered them truthfully and completely.

Signature ________________________________