Boisson Dental Group
#212, 11601-101 Ave.
Grande Prairie, AB T8V2H1

(587)771-7668

Medical History

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Medication
- ☐ Allergy - *See Notes
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Iodine
- ☐ Allergy - Latex
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy-Erythromicin
- ☐ Allergy-Local Anesth
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Contraceptive Use
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Excessive Bruising
- ☐ Gastro-Intestinal
- ☐ Glaucoma
- ☐ Hard To Freeze
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Hearing Disabled
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV+ (AIDS)
- ☐ Hives
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tuberculosis

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- [ ] Tumors
- [ ] Ulcers
- [ ] Wheelchair

- [ ] Ever been hospitalized (illness or injury)
- [ ] Subject to frequent headaches
- [ ] FEMALE: Taking birth control pills
- [ ] Presently being treated for any other illnesses
- [ ] Tobacco/Alcohol Use
- [ ] FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

* [ ] By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: