Lakeshore **W**est **D**ental
3390 Lake Shore Blvd., W. Office: 416-251-5707
Etobicoke, Ontario, M8W 1M9 www.lakeshorewestdental.com

DATE _____

PATIENTS NAME _____

DATE OF BIRTH (MM/DD/YR) _____

REASON FOR VISIT _____

MEDICAL HISTORY. Please circle, if you now have or ever have had any of the following.

A.I.D.S	Glaucoma	Mental/nervous disorder
Anemia	Head/neck injuries	Mitral valve prolapse
Angina pectoris	Heart disease or attack	Organ transplant/medical implant
Arthritis/rheumatism	Heart murmur	Psychiatric treatment
Artificial heart valve	Heart pacemaker	Radiation treatment/chemotherapy
Artificial joints (hip, knee)	Heart rhythm disorder	Scarlet fever / Rheumatic fever
Blood disorders	Heart surgery	Sickle cell disease
Bronchitis	Hepatitis A B C	Sinus trouble
Cancer	Herpes	Stomach/intestinal problems/ulcers
Circulation problems	High/Low blood pressure	Stroke
Congenital heart lesions	Hodgkins disease	Thyroid disease
Cortisone/steroid	Inflammatory bowel disease	Tuberculosis
Crohn's disease	Jaundice	Venereal Disease
Diabetes	Kidney disease	Other _____
Emphysema	Liver disease	Other_____
Epilepsy or seizures	Lung disease	Other _____
Fainting or dizzy spells	Lupus	Other_____
Glandular disorders	Malignant Hyperthermia	Other_____

NONE OF THE ABOVE ☐

Please circle YES or NO to the following questions. If YES please specify.

*Have you ever had any injury or surgery to your face or jaws?	NO	YES _____
*Are you allergic or sensitive to any medicines or anything used in the dental office such as latex or metal?	NO	YES _____
*Have you been hospitalized in the last 10 years?	NO	YES _____
*Are you taking any medicines now?	NO	YES _____
Please list Medications_____		
_____		
*Do you wear contact lenses?	NO	YES _____
*Do you smoke?	NO	YES _____
*Have you had any previous surgery?	NO	YES _____
*Have you ever had an unusual reaction to local or general anaesthesia?	NO	YES_____
*For Females; Are you pregnant or suspect you could be pregnant?	NO	YES _____

To the best of my knowledge the above information is correct.

_____ _____
Patient/parent guardian signature Date