VANCOUVER
Smile Studio
A GALLON FAMILY DENTAL PRACTICE

Medical History

Name: _____ Phone #: _____ Birth date: _____
day / month / year

Address: _____ Postal Code _____

Physician's name: _____ Physician's Phone #: _____

Have you had a **medical exam** in the past 12 months? _____ Yes No

Have you had any **serious illnesses or operations** in the past? _____ Yes No

If yes, describe: _____

Do you **smoke** or have you ever smoked? _____ Yes No

Do you have any **allergies**? _____ Yes No

If yes, please list: _____

Are you taking any **prescription or over the counter medications**? _____ Yes No

If yes, please list: _____

Are you taking any **herbal medications** such as Kava kava, St. John's Wort, garlic etc.? _____ Yes No

If yes, please list: _____

Do you take **blood thinning medication** such as Coumadin, Aspirin, etc? _____ Yes No

Do you often feel **over tired or sleepy** during the day? _____ Yes No

Has anyone witnessed you **stop breathing during sleep**? _____ Yes No

Do you **snore**? _____ _____ Yes No

How would you rate how you feel about your teeth and dental health from 1 to 10? _____/10

Have you ever had or would be interested in knowing more about:

Botox ____ Yes No Smile Design ____ Yes No Tooth Whitening_____ Yes No

Please check the box if you have ever had or been treated for any of the following:

- □ Heart disease or condition
- □ High/low blood pressure
- □ Blood disorder
- □ Stroke
- □ Artificial heart valves/stents
- □ Epilepsy or seizures
- □ Joint replacement
- □ Cancer
- □ Diabetes
- □ Arthritis
- □ Osteoporosis
- □ Lung disease or tuberculosis
- □ Asthma
- □ Sleep apnea
- □ Malignant hyperthermia
- □ Herpes or cold sores
- □ Ulcer or intestinal condition
- □ Stomach problems/GERD
- □ Anemia
- □ Kidney/bladder problems
- □ Glaucoma
- □ Rheumatic fever
- □ Mental or nervous disorder
- □ Venereal disease
- □ HIV/AIDS
- □ Hepatitis (circle) A B C
- □ Headaches

Any other condition not listed above? Please describe: _____
_____

Women: Are you **pregnant**? _____ Yes No
Are you taking **birth control**? _____ Yes No

In case of emergency please notify: _____ Relationship: _____ Phone # : _____

I certify that the information given in this document is correct

Patient Signature: _____ Date: _____
(signature of parent or guardian for patients under 18)