BURTCH DENTAL

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#9-1455 HARVEY AVENUE
KELOWNA BC V1Y 6E9

MEDICAL HISTORY

Name:________________________________ Date of Birth:_____________________
Physician:______________________________ Pharmacy:________________________
Your Medical history information is very important for your safety in our dental office.

Allergies: ____
List any medications, supplements and or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

Please circle if you have had any of the following:

Heart Attack – Heart Murmur -	Y N	Diabetes Type I or 2	Y N
Cancer – chemotherapy or radiation	Y N	Stomach or digestive disorders	Y N
Rheumatic fever	Y N	Arthritis	Y N
Scarlet fever	Y N	Glaucoma or contact lenses	Y N
High or low blood pressure	Y N	Head or neck injuries	Y N
Stroke	Y N	Epilepsy, seizures	Y N
Artificial Prosthesis (heart valve or joint)	Y N	Viral infections and cold sores	Y N
Anemia or other blood disorder	Y N	Any lumps or swelling in mouth	Y N
Prolonged bleeding due to a slight cut	Y N	HIV/AIDS/ Hepatitis___	Y N
Emphysema – tuberculosis –	Y N	Headaches/Migraines	Y N
Asthma or Respiratory disorder	Y N	Drug or alcohol dependency	Y N
Sinus problems	Y N	Mental health issues	Y N
Kidney or liver disease	Y N	Hospitalized in the past 5 years	Y N
High cholesterol	Y N	Do you Smoke?	Y N

Any other diseases, conditions or problems not listed above ________________________
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Dental History

Date of your last visit to a Dentist: ________________Reason for visit:______________

Do you experience any of the following:

Sites of pain /discomfort? Y or N   Bleeding Gums? Y or N
Growths or Sore Spots? Y or N   Clenching or Grinding? Y or N
What concerns do you have about your teeth/oral health:_____________________________
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Patient Signature:___________________________ Date:_____________________________