Date: _____

OWEN SOUND DENTAL CLINIC
MEDICAL UPDATE QUESTIONAIRE

Please answer the questions as accurately as possible. If you have any questions, please ask your treating dentist, dental assistant, hygienist or receptionist. All information provided is strictly confidential and will remain with this office. Please print when filling out this questionaire. If under the age of 16 please have a parent or guardian sign below.

Name:_____ Adult Child Date of Birth_____
Last name, First name D/M/Y

Address:_____

Cell#_____Home#_____

Email address:_____

Emergency Contact: _____ Relation:_____

Phone#: _____

MEDICAL INFORMATION

Name of Family Physician: _____Phone #: _____

Address: _____

Health card #: _____

Preferred Pharmacy: _____ Phone #: _____

Are you seeking treatment from a Medical Specialist? Yes No . Phone#: _____

Please List your current Prescription and non-prescription medication, or herbal supplements. If you are currently not taking any medication please indicate none below:

_____

_____

_____

When was your last visit with your physician? _____

Have you had any change in your general health over the past year? Yes No If yes, please explain:_____

Are you being treated for any medical condition presently? Yes No If yes please specify_____

Please complete both pages.

Do you have, or have you ever had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Allergies Medication, Latex			Fainting or dizziness			Seizures		
Arthritis			Hepatitis A, B or C			Shortness of Breath		
Artificial joints			HIV or AIDS			Sinus Problems		
Asthma			Heart Problems(Attack,murmur)			Steroid Therapy		
Bone Disorders			Heart Surgery(By-pass, valve replacement, pacemaker)			Stomach Ulcers		
Bleeding Disorders			High or Low Blood Pressure			Stroke		
Cancer or tumor			Kidney or Liver Disease			Thyroid Issues		
Chest pain/Angina			Lung Disease			Tuberculosis		
Diabetes			Mental Health Issues			Do you smoke or vape?		
Drug/Alcohol Dependency			Radiation to head or neck			Do you use cannabis if so what form do you use(smoking, oils etc.)		
Epilepsy			Respiratory Problems			Are there any conditions which you have but is not listed?		
Dementia/ Alzheimers			Do you need to take pre-medication(antibiotic) prior to dental treatment?			Do you have any disabilities? (eg. Visual, mobility, hearing, developmental etc.)		

General Release

I understand and certify that I have provided an accurate and complete medical history update and have not knowingly omitted any information.

X_____ _____

Signature of Patient, Parent or Guardian Please print Name of Guardian