Energy Square Prosthodontics / Central Alberta Prosthodontics

Registered Specialists in Prosthodontics and Restorative Dentistry

Vital Signs (office use only)

Existing Patient Medical History Update

Name ______________________
Surname First

Address ______________________
Street City Province

Postal Code __________ Phone (home) __________ Phone (cell) __________

Email __________ Phone (work) __________ Ext # ______

Employer __________ Occupation __________

Dental Insurance __________ Group # __________ ID # __________
Policy Holder/Insurance Company

__________ Group # __________ ID # __________
Policy Holder/Insurance Company

Estimation of General Health: ☐ Good ☐ Fair ☐ Poor BP (Office Use Only)

Last Medical Exam __________ Physician's Name __________

Has there been any recent change in your health status: ◯ Y ◯ N

If yes, explain: __________

Have you been under constant care of a physician in the past 5 years? ◯ Y ◯ N

If yes, explain: __________

Any new allergies? ◯ Y ◯ N Explain __________

Do you require any pre-medication prior to dental appointments? ◯ Y ◯ N Explain __________

Women Only: Are you pregnant? ◯ Y ◯ N Which Trimester? __________

Current Prescribed Medication including Over the Counter Medications/Supplements:

Have you ever had or been treated for any of the following?
Heart Disease, Blood Pressure Problems, Heart Murmur, Mitral Valve Prolapse, Rheumatic Fever, Thyroid Problems, Stomach Ulcer, Hay Fever, Asthma, Allergies, Sinusitis, Frequent Colds, Lung Disease, Diabetes, Epilepsy, Gall Bladder Problems, Tuberculosis, Kidney or Liver Issues, Hysterectomy, Blood Disorders, Cancer, Leukemia, Seizures, Hepatitis, Jaundice, HIV or similar, STD's, Stroke, Arthritis, Glaucoma, Prosthetic or Artificial Joint , Pacemaker

Please describe:

Have you ever experienced any of the following signs and/or symptoms within the last year:

☐ Shortness of Breath ☐ Chest Pain ☐ Bruising
☐ Nausea ☐ Abnormal Bleeding ☐ Blurred Vision
☐ Dizziness ☐ Swelling ☐ Chronic Headaches

Nutrition (Indicate amount per day): Smoking ☐ Coffee ☐ Milk ☐ Sweets ☐

Is there any other pertinent information in your medical history that is not listed above? ◯ Y ◯ N

If yes, explain

Date Patient or Guardian's Signature Dentist's Signature