Energy Square Prosthodontics / Central Alberta Prosthodontics

Registered Specialists in Prosthodontics and Restorative Dentistry

New Patient Medical History

Vital Signs (office use only)

Last Medical Exam ____ Physician's Name ____ Last Eye Exam ____

Estimation of General Health ◯ Good ◯ Fair ◯ Poor

If poor, please explain ____

Current Prescribed Medication including Over the Counter Medications/Supplements/Recreational:

____

	Yes	No	
Do you require any pre-medication prior to dental appointments?	◯	◯	
Has there been any recent change in your health?	◯	◯	
Have you been under the constant care of a physician in the past 5 years?	◯	◯	If yes, please explain. ____
Have you ever had a serious illness?	◯	◯	If yes, please explain. ____
Have you ever been hospitalized?	◯	◯	If yes, please explain. ____
Have you taken steroids (cortisone) in the past 2 years?	◯	◯	
Do you have **Allergies to Medication**?	◯	◯	If yes, please list. ____
Has your weight changed recently?	◯	◯	
Have you ever had radiation or chemotherapy?	◯	◯	
Do you get infections easily?	◯	◯	
Do you wear contact lenses?	◯	◯	
Are you under excessive tension or stress?	◯	◯	If yes, please explain. ____
Do you heal rapidly?	◯	◯	
Is there a history of family disease?	◯	◯	If yes, please explain. ____
Do you often feel tired, fatigued, or sleepy during daytime?	◯	◯	____
Have you ever been told that you snore?	◯	◯	____
Have you been treated for sleep disorder/apnea?	◯	◯	____
Women Only - Are you pregnant?	◯	◯	Which trimester? ____

Have you ever had or been treated for any of the following (please circle)

Allergies, Alzheimer's Disease, Arthritis, Asthma, Blood Disorders, Blood Pressure Problems, Cancer, Diabetes, Epilepsy, Frequent Colds, Gall Bladder Problems, Glaucoma, HIV or similar, Hay Fever, Heart Disease, Heart Murmur, Hepatitis, Hysterectomy, Jaundice, Kidney or Liver Issues, Latex Allergy, Leukemia, Lung Disease, Mitral Valve Prolapse, Pacemaker, Prosthetic or Artificial Joint, Rheumatic Fever, STD's, Seizures, Sinusitis, Stomach Ulcer, Stroke, Thyroid Problems, Tuberculosis

Have you ever experienced any of the following signs and/or symptoms within the last year (please circle)

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

Indicate amount per day Smoking ____ Coffee ____ Milk ____ Sweets ____ Alcohol ____

Is there any other pertinent information in your medical history not listed above of which we should be aware?

____

Date ____ Patient's Signature (or Guardian) ____ Dentist's Signature ____