MEDICAL HISTORY

RECORD

Approved by:	J. Hills	J. Wu	REC005-V04-10/13
	Responsible Head *(Signature on file)*	**Quality** *(Signature on file)*	**Document #**

Patient's Surname _____ Given Name _____ dd-MMM-yy Date of Birth

In the following sections, please answer the questions and check (☑) any medical conditions that apply to you:

Please ask for help if you do not understand any questions

1. HEALTH HISTORY

☐ Heart Problems
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ **Prosthetic Heart Valve*
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ **Congenital Heart Disease*
- ☐ **History of Endocarditis*

☐ High Blood Pressure

☐ Lung Problems
- ☐ Bronchitis
- ☐TB
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Asthma

☐ Endocrine
- ☐ Diabetes
  - ☐ Type I ☐ Type II
- ☐ Thyroid Problems

☐ Joint/Bone Problems
- ☐ Arthritis
- ☐ **Total Joint Replacements*
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis

☐ Bleeding Problems/Disorders
- ☐ Blood Clots
- ☐ Anemia

☐ Blood Transfusion:

When? _____

_____

Why? _____

_____

☐ Stomach / Bowel Problems
- ☐ Acid taste when lying down
- ☐ Gastric or Duodenal Ulcer
- ☐ Crohn's / Colitis

☐ Organ Transplant

☐ Kidney/Bladder Problems

☐ Skin Condition Problems

☐ Seizures

☐ Blackouts

☐ Rheumatic Fever

☐ Hepatitis / Jaundice / Liver Disease

☐ Jaw / Neck Problems

☐ Steroid Therapy

☐ Glaucoma

☐ Depression / Mental Illness

☐ Drug / Alcohol Dependence

☐ Weight Gain / Loss

☐ Infectious Diseases

☐ Sexually Transmitted Diseases

☐ Immunocompromised
- ☐ **Neutropenia*
- ☐ **Hematologic Malignancies (Leukemia / Hodgkin's Disease)*
- ☐ HIV / AIDS

☐ Stroke / TIA or Mini-stroke

☐ Systemic Lupus Erythematosus

☐ Conditions that run in the family

i.e. muscular dystrophy, heart disease

Please Specify: _____

_____

_____

WOMEN ONLY

☐ Currently Pregnant Due Date: _____

☐ Breast Feeding

Other condition(s) not mentioned above (please specify):

**Pertinent medical history to consider when determining the need for Antibiotic Prophylaxis*

Patient No.: | | | | | | | | |

2. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Yes ☐ No
If Yes, Please List:

Name	Dose

3. Do you have allergies to anaesthetics (local/general), medication, food or material? ☐ Yes ☐ No
If Yes, Please List:

Allergy	Reaction

4. Any previous hospitalization and/or surgeries? ☐ Yes ☐ No
If Yes, Please List:

Reason	When	Where	Complications (if any)

5. Have you been under the care of a physician (s) during the past 5 years? ☐ Yes ☐ No
If Yes, Please List:
Name of Physician (s): _____ **Area of Specialty** _____

Date of last Medical Check-up: _____ With Whom: _____ (Family Physician / Specialist)

6. Have you ever received any of the following therapy?

Therapy	Yes	No	When	Facility Location
Radiation				
Chemotherapy				
Hyperbaric Oxygen Treatment				

7. Do or did you ever smoke or chew tobacco products? ☐ Yes ☐ No
If Yes, Identify type(s) of tobacco product:
☐ cigarette ☐ cigar ☐ pipe ☐ chew tobacco ☐ snuff ☐ other: _____

Number of years: _____ Pack / day: _____

Quit? ☐ Yes ☐ No If yes: Identify date quit: _____

8. Do you drink alcohol? ☐ Yes ☐ No If yes, how often: ☐ Daily ☐ Weekly ☐ Rarely
9. Do you use street drugs? ☐ Yes ☐ No If yes, Identify Type: _____

Thank you for your assistance in completing your medical history. This information is confidential and will only be shared with professionals involved in your care.

Date Completed: dd-MMM-yy Signature: _____ Patient or Legal Guardian

Form completed by:

☐ Patient ☐ parent/family/friend ☐ clinical staff ☐ administration | ☐ mail ☐ telephone ☐ in person

Patient No.: | | | | | | | | |