Medical & Dental History

Uplands Dental Clinic - Dr.Haslam & Dr.Leigh

Patient Information

Title | Patient Name | Date of Birth | Age | Gender
- Male
- Female
- Other

Address (street name, unit #) | City | Province | Postal Code

Primary Phone | Secondary Phone | Email Address

Preferred contact method
- Phone
- Email

Family Physician Name | Physician Phone

Emergency Contact | Primary Phone | Relationship

Medical Information

Do you have or have you ever had any of the following?

- ☐ AIDS/HIV
- ☐ Auto-Immune Diseases
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (specify below)
- ☐ Chemotherapy
- ☐ Chest Pain/Angina
- ☐ Crohn's/IBS
- ☐ Diabetes
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy - Seizures
- ☐ Esophageal Re-flux (GERD)
- ☐ Fainting
- ☐ Heart Attack
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Insulin
- ☐ Jaundice
- ☐ Joint Replacement (specify date below)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Migraine Headaches
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prosthetic Heart Valve
- ☐ Radiotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumours (specify below)
- ☐ Transplants (specify below)

Please specify any additional details to supplement the previous section

Please list any medications/supplements being taken (attach a list if multiple)

Please list any known allergies

Please list any hospitalizations in the past 2 years

Please list any surgeries

Please list any recreational substances you take and frequency

Do you suffer from, or have a family history of malignant hyperthermia

Yes No

Are you taking blood thinners?

Yes No

Do you have problems with your bleeding time?

Yes No

WOMEN ONLY - Are you pregnant? If yes, how many months?

Yes No

WOMEN ONLY - Are you nursing?

Yes No

Dental Information

When was your last dental visit?

What was the reason for your visit?

Are you having any problems that require immediate attention?

Are you nervous during dental treatment?

- Yes
- No

Do you currently have or have you ever had any of the following? Check all that apply:

- [ ] Bleeding gums when you brush your teeth
- [ ] Clenching/Grinding
- [ ] Jaw Pain
- [ ] Loose Teeth
- [ ] Orthodontic Treatment
- [ ] Periodontal Treatment
- [ ] Swelling of the face/neck
- [ ] Sleep Apnea
- [ ] Temperature Sensitivity
- [ ] Tooth Pain

Are you interested in any of the following? Check all that apply

- [ ] Bridge/Dentures
- [ ] Straightening Teeth
- [ ] Dental Crowns
- [ ] Teeth Whitening
- [ ] Dental Implants

Cancellations and Missed Appointments

Your appointment time has been exclusively for you to see the dentist or hygeinist. We ask that you give us at least 48 hours advance notice when cancelling your schedules appointmnet so that we may offer the time to another patient.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided I will advise this dental office. I understand that information provided from or to my medical doctor or healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used, and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Signature (patient/guardian)

Date: ____________________

Dentist Signature

Date: ____________________