ENDO PERIO CALGARY

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Patient Medical Record

Patient:_____ Date:_____
Why is the patient here today?_____
Patients Age:_____ Height:_____ Weight:_____

Allergies (medications, food, iodine, latex, tape, etc.)	Type of Allergic Reaction

Current Medications:
(includes herbals/vitamins, prescribed and over-the-counter, taken regularly or as needed)

Name of Drug	Amount/How Often	Reason for Taking	Last Time Taken

Patient/Family problem with anesthesia? No☐ Yes☐ If yes, explain:_____
(Nausea, prolonged paralysis, problems waking up, malignant hyperthermia)
Possibility of patient pregnancy? No☐ Yes☐ N/A☐
Last normal menstrual period: _____

Past Medical History
Physician's name and address:_____ Date of last exam:_____
Have you ever been hospitalized? No☐ Yes☐ if yes, what for?_____
Have you ever been tested for hepatitis A, B or C? No☐ Yes☐ If yes, which hepatitis virus?___
Have you had any recent exposure to communicable infectious diseases (measles, chicken pox, TB, prion disease, or travelled to an endemic area)? No☐ Yes☐ If yes:_____
In the last 24 hours have you had a new cough, fever, chills, diarrhea, or other flu like symptoms?
No☐ Yes☐ If yes, please explain:_____

Medical History (Please check all the appropriate illness)

☐ Heart disease / Murmur / Angina	☐ Neurological Problems	☐ Thyroid Problems
☐ Kidney / Bladder Problems	☐ Depression / Anxiety	☐ High Cholesterol
☐ Anemia or Blood Problems	☐ High Blood Pressure	☐ Psychiatric Care
☐ Liver Problems / Hepatitis	☐ Low Blood Pressure	☐ Sinus Problems
☐ Eye Disorder / Glaucoma	☐ Shortness of Breath	☐ Swollen Ankles
☐ Headaches / Migraines	☐ Seasonal Allergies	☐ Ear Problems
☐ Lung Problems / Cough / Asthma	☐ Heartburn (reflux)	☐ Ulcers / Colitis
☐ Tonsillitis	☐ Diabetes	☐ Seizures
☐ Arthritis	☐ Cancer	☐ Stroke

Please list your weekly usage of the following:
Tobacco_____ Alcohol_____ Recreational Drugs_____
Please describe any current or past medical treatment not listed above:_____
_____
Please list any past surgeries:_____
Additional comments:_____
By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.
Patient / Legal Guardian Signature:_____ Date:_____
Name of Person Driving Patient Home (sedation only):_____ Phone:_____
Reviewed by:_____ Date: _____
(Doctor Signature)