NIAGARA PENINSULA
ORAL SURGERY

Medical History

rev. Sept 2021

Patient Name:____

1) Are you being treated for any medical conditions by a physician? If yes, please explain: ________ Yes No

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2) Have you been Hospitalized recently? Explain: ____ Yes No

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3) Are you taking any Medications or Drugs at the present time? ____________________________ Yes No

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4) Have you ever had any Surgery? If yes, please explain: ______________________________ Yes No

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5) Do you have any Allergies? (Food, drug, etc.) ____ Yes No

6) Women: Are you pregnant now? Weeks _____________ Due date:___________________ Yes No

7) Tobacco Use: Yes No Recreational Drug Use: Yes No

8) Use of Bisphosphonates? (Fosamax, Actonel) to treat Osteoporosis ________________________ Yes No

9) Have you had your second Covid-19 vaccination greater than 14 days ago? Date:_______________ Yes No

Please indicate with a check mark if you ever had or been treated for any of the following:

Rheumatic Fever	_____	Jaundice	_____	Chronic Cough	_____	Mononucleosis	_____
Heart Murmur	_____	Hepatitis	_____	Asthma/ Sinus	_____	Epilepsy	_____
Mitral Valve Prolapse	_____	Liver Problems	_____	Tuberculosis	_____	Psychiatric Care	_____
Heart Disease	_____	Bleeding Problems	_____	Difficulty Breathing	_____	Malignant Hyperthermia	_____
Heart Attack	_____	Ulcers	_____	Thyroid Problems	_____	Cancer	_____
Angina	_____	High Blood Pressure	_____	Diabetes	_____	Radiation or Chemotherapy	_____

Are there any other conditions not previously noted that we should be aware of? ___________________________

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Patient or Guardian's Signature: ______________________________ THANK YOU FOR YOUR CO-OPERATION

Office Use:
CANATRACE /Dates : ______________ /______________ /__________________ /__________________

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Reviewed by: ___________________________________ Date: ___________________