ILDERTON
DENTAL CARE

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Dates: YYYY-MM-DD (for example 2026-10-01). Leave anything you'd rather discuss in person; a blank is not a "No".

Background

Name of physician

Physician phone #

Name of any specialist

Specialist phone #

Have you been under a physician's care during the last 2 years? ○ Yes ○ No

For?

Have you been treated in the hospital in the last 2 years? ○ Yes ○ No

For?

Have you ever had major surgery? ○ Yes ○ No

Are you taking hormones or birth control?
○ Yes ○ No ○ Doesn't apply

Are you pregnant or nursing?
○ Yes ○ No ○ Doesn't apply

Have you had a blood test for hepatitis? ○ Yes ○ No

Were you vaccinated for hepatitis? ○ Yes ○ No

Have you had cankers/cold sores on your lips/tongue/body? ○ Yes ○ No

Are you now or have you taken any prescription drug in the past year? ○ Yes ○ No

For? (up to 1000 characters; use the continuation page for more)

Allergies

Are you allergic to:
☐ Penicillin ☐ Codeine ☐ Local anaesthetics ☐ Metal ☐ Latex ☐ Other

Other allergy

Have you had or do you have:

Blood Disorders	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No
Bleeding Easily	◯ Yes	◯ No
Blood Transfusions	◯ Yes	◯ No
Heart Disease	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No
Congenital Heart Defects	◯ Yes	◯ No
Rheumatic Heart Defects	◯ Yes	◯ No
Rheumatic/Scarlet fever	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
Angina/Heart Attack Pain	◯ Yes	◯ No
Stroke or Blood Clots	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Radiation Therapy	◯ Yes	◯ No
Malignant Hyperthermia	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Asthma/Hay Fever	◯ Yes	◯ No
Pneumonia/Pleurisy	◯ Yes	◯ No
Breathing Disorders	◯ Yes	◯ No
Coughing Up Blood	◯ Yes	◯ No
Hormone Disorder	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Adrenal Disease	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No

Venereal Disease	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
AIDS/HIV	◯ Yes	◯ No
Rheumatoid Arthritis	◯ Yes	◯ No
Skin Rash/Hives Disorder	◯ Yes	◯ No
Stomach/Bowel Disorder	◯ Yes	◯ No
Stomach Ulcers	◯ Yes	◯ No
Colitis	◯ Yes	◯ No
Loss of Appetite/Eating Disorder	◯ Yes	◯ No
Difficulty Swallowing	◯ Yes	◯ No
Severe Diarrhea	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Cirrhosis of the Liver	◯ Yes	◯ No
Hepatitis A	◯ Yes	◯ No
Hepatitis B	◯ Yes	◯ No
Hepatitis Other	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Drug Dependency	◯ Yes	◯ No
Eye Disease	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Double Vision/Dizziness	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No
Ear Disorders	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No
Psychiatric Problems	◯ Yes	◯ No
Contact Lenses	◯ Yes	◯ No
Organ transplant	◯ Yes	◯ No
Pins/Plates/Artificial Joints	◯ Yes	◯ No
Seizures/Fainting Spells	◯ Yes	◯ No

Attestation

Do you have any other disease, condition or factor in your medical history which we should know about?

◯ Yes ◯ No

If yes, please comment: (up to 2000 characters; use the continuation page for more)

☐ The above medical profile is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Signing as ○ Patient ○ Parent ○ Guardian

Name

Signing: type your full name below, or print this page and sign by hand. A typed name is not a certified digital signature; you can also sign at the clinic.

Signature

Date (YYYY-MM-DD)

Continuation page

Use this page if any answer needs more room. Write the question it continues.