Oliver Dental Care
Dr. Jordan Noftle DMD. BSc, BEd

MEDICAL HISTORY

Phone: 250.498.2323 | Email: info@oliverdentalcare.com

Medical Alert - For Dentist's use Only

PATIENT NAME First Name, Last Name **NICKNAME** First Name, Last Name **AGE** Age

NAME OF PHYSICIAN/AND THEIR SPECIALTY First Name, Last Name / Specialty

MOST RECENT PHYSICAL EXAMINATION Please Specify **PURPOSE** Please Specify

WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. Hospitalization for illness or injury Notes (if needed) ☐ Y ☐ N
2. An allergic or bad reaction to any of the following: ☐ Y ☐ N
   - ☐ Aspirin, ibuprofen, acetaminophen, codeine Notes (if needed)
   - ☐ Penicillin Notes (if needed)
   - ☐ Erythromycin Notes (if needed)
   - ☐ Tetracycline Notes (if needed)
   - ☐ Sulfa Notes (if needed)
   - ☐ Local anesthetic Notes (if needed)
   - ☐ Fluoride Notes (if needed)
   - ☐ Chlorhexidine (CHX) Notes (if needed)
   - ☐ Iodine Notes (if needed)
   - ☐ Metals (nickel, gold, silver,) Notes (if needed)
   - ☐ Latex Notes (if needed)
   - ☐ Nuts Notes (if needed)
   - ☐ Fruit Notes (if needed)
   - ☐ Milk Notes (if needed)
   - ☐ Red dye Notes (if needed)
   - ☐ Other Notes (if needed)
3. Heart problems, or cardiac stent within the last six months Notes (if needed) ☐ Y ☐ N
4. History of infective endocarditis Notes (if needed) ☐ Y ☐ N
5. Artificial heart valve, repaired heart defect (PFO) Notes (if needed) ☐ Y ☐ N
6. Pacemaker or implantable defibrillator Notes (if needed) ☐ Y ☐ N
7. Orthopedic or soft tissue implant (e.g., joint replacement, breast implant) Notes (if needed) ☐ Y ☐ N
8. Heart murmur, rheumatic or scarlet fever Notes (if needed) ☐ Y ☐ N
9. High or low blood pressure Notes (if needed) ☐ Y ☐ N
10. A stroke (taking blood thinners) Notes (if needed) ☐ Y ☐ N
11. Anemia or other blood disorder Notes (if needed) ☐ Y ☐ N
12. Prolonged bleeding due to a slight cut (or INR > 3.5) Notes (if needed) ☐ Y ☐ N
13. Pneumonia, emphysema, shortness of breath, sarcoidosis Notes (if needed) ☐ Y ☐ N
14. Chronic ear infections, tuberculosis, measles, chicken pox Notes (if needed) ☐ Y ☐ N
15. Breathing problems (e.g., asthma, stuffy nose, sinus congestion) Notes (if needed) ☐ Y ☐ N
16. Sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) Notes (if needed) ☐ Y ☐ N
17. Kidney disease Notes (if needed) ☐ Y ☐ N
18. Liver disease or jaundice Notes (if needed) ☐ Y ☐ N
19. Vertigo (e.g., "the room is spinning") Notes (if needed) ☐ Y ☐ N
20. Thyroid, parathyroid disease, or calcium deficiency Notes (if needed) ☐ Y ☐ N
21. Hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) Notes (if needed) ☐ Y ☐ N
22. High cholesterol or taking statin drugs Notes (if needed) ☐ Y ☐ N
23. Diabetes (HbAlc =) Notes (if needed) ☐ Y ☐ N
24. Stomach or duodenal ulcer Notes (if needed) ☐ Y ☐ N
25. Digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) Notes (if needed) ☐ Y ☐ N
26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) Notes (if needed) ☐ Y ☐ N
27. Arthritis or gout Notes (if needed) ☐ Y ☐ N
28. Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) Notes (if needed) ☐ Y ☐ N
29. Glaucoma Notes (if needed) ☐ Y ☐ N
30. Contact lenses Notes (if needed) ☐ Y ☐ N
31. Head or neck injuries Notes (if needed) ☐ Y ☐ N
32. Epilepsy, convulsions (seizures) Notes (if needed) ☐ Y ☐ N
33. Neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) Notes (if needed) ☐ Y ☐ N
34. Viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) Notes (if needed) ☐ Y ☐ N
35. Any lumps or swelling in the mouth Notes (if needed) ☐ Y ☐ N
36. Hives, skin rash, hay fever Notes (if needed) ☐ Y ☐ N
37. STI/STD/HPV Notes (if needed) ☐ Y ☐ N
38. Hepatitis (type) Notes (if needed) ☐ Y ☐ N
39. HIV/AIDS Notes (if needed) ☐ Y ☐ N
40. Tumor, abnormal growth Notes (if needed) ☐ Y ☐ N
41. Radiation therapy Notes (if needed) ☐ Y ☐ N
42. Chemotherapy, immunosuppressive medication Notes (if needed) ☐ Y ☐ N
43. Difficulties with stress management Notes (if needed) ☐ Y ☐ N
44. Psychiatric treatment, antidepressants, mood stabilizing medications Notes (if needed) ☐ Y ☐ N
45. Concentration problems or ADD/ADHD Notes (if needed) ☐ Y ☐ N
46. Alcohol/recreational drug use Notes (if needed) ☐ Y ☐ N

ARE YOU:

47. Presently being treated for any other illness Notes (if needed) ☐ Y ☐ N
48. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) Notes (if needed) ☐ Y ☐ N
49. Taking medication for weight management Notes (if needed) ☐ Y ☐ N
50. Taking dietary supplements, vitamins, and/or probiotics Notes (if needed) ☐ Y ☐ N
51. Often exhausted or fatigued Notes (if needed) ☐ Y ☐ N
52. Experiencing frequent headaches or chronic pain Notes (if needed) ☐ Y ☐ N
53. A smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) Notes (if needed) ☐ Y ☐ N
54. considered a touchy/sensitive person Notes (if needed) ☐ Y ☐ N
55. often unhappy or depressed Notes (if needed) ☐ Y ☐ N
56. taking birth control pills Notes (if needed) ☐ Y ☐ N
57. currently pregnant Notes (if needed) ☐ Y ☐ N
58. diagnosed with a prostate disorder Notes (if needed) ☐ Y ☐ N

DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, GENETIC/DEVELOPMENT DELAY, OR OTHER TREATMENT THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT. (I.E. BOTOX, COLLAGEN INJECTIONS

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS (YOU MAY ALSO USE THE BACK OF THIS FORM)

Drug Drug Name Purpose Please Specify
Drug Drug Name Purpose Please Specify
Drug Drug Name Purpose Please Specify
Drug Drug Name Purpose Please Specify
Drug Drug Name Purpose Please Specify
Drug Drug Name Purpose Please Specify

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature First Name, Last Name Date YYYY / MM / DD

Dentist's Signature First Name, Last Name Date YYYY / MM / DD

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