

Health History:

- > Have you been hospitalized recently? \_\_\_\_ For what? \_\_\_\_\_
- > Approximate date of last physical exam: \_\_\_\_\_
- > Physicians name: \_\_\_\_\_
- > Are you taking any medications or herbal supplements? \_\_\_\_\_  
If so, what? \_\_\_\_\_  
\_\_\_\_\_
- > Have you recently experienced any chest pain? \_\_\_\_\_
- > Do you regularly experience shortness of breath? \_\_\_\_\_
- > Have you experienced prolonged or abnormal bleeding with previous extractions, Surgery or trauma? \_\_\_\_\_
- > Have you had any serious illness or operation? \_\_\_\_\_
- > Have you had surgery or x-ray (radiation) therapy for a tumour, growth or other condition? \_\_\_\_\_
- > Do you have, or have had any of the following? (please circle Yes or No).  
Y/N rheumatic fever      Y/N heart disease      Y/N heart attack  
Y/N cancer \_\_\_\_\_  
Y/N high blood pressure    Y/N stroke                      Y/N seizures                      Y/N anemia  
Y/N low blood pressure    Y/N asthma                      Y/N diabetes  
Y/N AIDS/HIV              Y/N hepatitis                      Y/N hives or skin rash  
Y/N liver disease              Y/N Hepatitis A, B, C, E  
Y/N venereal disease      Y/N GI condition/ulcer      Y/N tuberculosis  
Y/N sinus trouble              Y/N fainting spells      Y/N jaundice  
Y/N mental illness  
Y/N have you used illicit drugs                      Y/N intravenous needles
- > Are you allergic to: (please circle Yes or No)  
Y/N penicillin/ antibiotics                      Y/N Ibuprofen, Tylenol, Toradol  
Y/N sleeping pills, sedatives                      Y/N codeine  
Y/N topical (rub on) anesthetics                      Y/N local anesthetic  
Y/N latex                      Y/N environmental allergies
- > If so, what did you experience? \_\_\_\_\_
- > Any other allergies? \_\_\_\_\_
- > Do you have any health concerns not listed here? \_\_\_\_\_  
\_\_\_\_\_

> WOMEN: Are you pregnant? \_\_\_\_ Expected delivery date: \_\_\_\_\_

Physicians name: \_\_\_\_\_

Address or clinic name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dental photographs are essential for dentist/client communication. I, also hereby consent to and approve use by Dr. Paul Bonazza Dental Services Ltd of dental/facial photographs of me, for scientific or marketing purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please add additional notes/requests: \_\_\_\_\_  
\_\_\_\_\_