



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: _____