East Vancouver Dentistry

Hooman Shakiba, DMD

Patient Name:_____

DOB:_____ Sex: F M

Medical History

Do you have or have you ever had any of the following? *Circle Below*

Yes No Alergic Reaction(circle all that apply)
Latex Penicillin Aspirin Codeine Local Anesthetics Metal other:_____

Yes No Heart Attack or Heart Disease
Yes No Stroke
Yes No High Blood Pressure
Yes No Congestive Heart Failure
Yes No Angina (chest pains)
Yes No Irregular Heart Beat
Yes No Artificial Heart Valve
Yes No Rheumatic fever, Rheumatic Heart Disease
Yes No Bacterial Endocarditis (SBE)
Yes No Congenital Heart Disease
Yes No Heart Murmur or Mitral Valve Prolapse

Medication List:

_____
_____
_____
_____
_____
_____
_____
_____

Yes No Immunosuppressive Condition (circle all that apply)
Steroid Therapy (e.g.prednisone) Radiation Therapy Chemotherapy SLE (lupus)
Rhheumatoid Arthritis HIV Organ Transplant Spleen Removed Other:_____

Yes No Artificial Joint(s) (circle all that apply)

	Hip	Knee	Ankle	Shoulder	Other
Date Placed:					

Yes No Other Artificial implants or devices
Yes No Bleeding problem, anemia, other blood disease
Yes No Diabetes
Yes No Thyroid Disease
Yes No Nervous System disease or Seizures
Yes No Stomach or Intestinal Disease
Yes No Kidney Disease
Yes No Hepatitis *Circle Type:* A B C D
Yes No Other Liver Disease _____
Yes No Arthritis (osteo or rheumatoid)
Yes No Other muscle or Joint Disease _____
Yes No Asthma
Yes No Tuberculosis
Yes No Other Lung Disease _____
Yes No Mental Health condition- Specify:_____
Yes No Physical Or Mental Disabilities that may require special care
Yes No Do you have or have you ever been treated for Cancer?

For Women:

Yes No Are you or could you be Pregnant?
Yes No Are you nursing?