

Dr.
**Sherri
 Wise**

"exceptional dentistry"

Your medical history is critical to ensure your safety and comfort during your dental appointment. Please take a moment to fill out this form, then bring it with you to your first appointment.

If you have any questions about the form, please contact us by phone or email, or bring in your partially-completed form and we can discuss your questions in person.

Dr. Sherri Wise
 Oakridge Centre Mall
 Cambie at 41st, Unit #320
 Phone: 604.261.8262
 Email: info@wisedental.ca

w w w . w i s e d e n t a l . c a

○

Name _____ Insurance _____

Home Address _____ City _____ Postal Code _____ Date of Birth (mm/dd/yyyy) _____

Email _____ Home Number _____ Work Number _____ Employer _____ Occupation _____

Age _____ Sex _____ Height _____ Weight _____ Marital Status _____ Spouse's Name _____ Closest Relative _____ Referred by _____

- | | yes | no |
|--|-----------------------|-----------------------|
| 1 Have you had a medical exam in the last two years? | <input type="radio"/> | <input type="radio"/> |
| 2 Have you ever been hospitalized, had a major operation, or serious illness? | <input type="radio"/> | <input type="radio"/> |
| 3 Do you have a Family Doctor?
Name: _____ | <input type="radio"/> | <input type="radio"/> |
| 4 Are you taking any medication or drugs? | <input type="radio"/> | <input type="radio"/> |
| 5 Are you allergic to anything?
(i.e. penicillin, foods, medicines, latex, ect.) | <input type="radio"/> | <input type="radio"/> |
| 6 Have you had heart disease, a heart murmur, heart surgery, rheumatic fever, or scarlet fever? | <input type="radio"/> | <input type="radio"/> |
| 7 Have you ever required antibiotics before a dental cleaning? | <input type="radio"/> | <input type="radio"/> |
| 8 Do you have chest pain on exertion, or fainting spells? | <input type="radio"/> | <input type="radio"/> |
| 9 Have you ever been told you have high blood pressure? | <input type="radio"/> | <input type="radio"/> |
| 10 Have you ever had kidney disease, jaundice, hepatitis A, B, or C, HIV (AIDS), diabetes, or a thyroid problem? | <input type="radio"/> | <input type="radio"/> |
| 11 Do you have any blood disorders, anemia, bruise or bleed easily, or have you tested positive for HIV? | <input type="radio"/> | <input type="radio"/> |
| 12 Have you ever bled heavily after an extraction? | <input type="radio"/> | <input type="radio"/> |

- | | yes | no |
|--|-----------------------|-----------------------|
| 13 Have you ever had a peculiar reaction to a medicine or injection? (i.e. local anesthetic) | <input type="radio"/> | <input type="radio"/> |
| 14 have you had any prosthetic replacement surgery? (i.e. knee, hip, heart valve replacement?) | <input type="radio"/> | <input type="radio"/> |
| 15 If female: are you pregnant?
Due date: _____ | <input type="radio"/> | <input type="radio"/> |
| 16 have you ever had any disease or medical problems not listed?

_____ | <input type="radio"/> | <input type="radio"/> |
| 17 How long since your last dental visit? _____ months
about _____ years | | |

Signature _____ Date _____