w: drbrentmacdonald.ca
e: info@drbrentmacdonald.ca
p: 403-273-6959

DR. BRENT MACDONALD, DMD

PERSONAL INFORMATION

Name: _____Date:_____

Address: _____ City: _____Prov:_____PC_____

Phone Res: _____Cell:_____Bus:_____E-mail:_____

DOB: _____Gender: M___F___O___ Marital Status: M__ S___O___Occupation:_____

Person responsible for account: _____Phone: _____

Physician: _____Phone:_____Date of last medical examination: _____

Previous Dentist: _____Phone: _____Date of last dental examination: _____

Whom may we thank for referring you? _____

Emergency Contact: _____Phone:_____

HEALTH INFORMATION

Please add any necessary explanation to your answers.

Are you feeling pain or discomfort at this time? _____Y N

Have you had a medical examination in the last year? _____ Y N

Do you feel very anxious about having dental treatment? _____ Y N

Have you been a patient in the hospital during the last two years? _____Y N

Do you smoke? If yes, for how long and how many per day_____ Y N

Has your doctor or dentist ever said that you require antibiotics before dental treatment? _____Y N

Do you take blood thinners or have a problem with blood clotting? _____ Y N

Are you currently experiencing diarrhea, a persistent cough or an undiagnosed skin rash? _____Y N

Do you currently use any alcohol or cannabis products? _____Y N

Have you lost of gained more than 10 pounds in the last year? _____Y N

Are you on a special diet? _____Y N

Do you have a tendency to faint? _____Y N

Are you presently pregnant or nursing? _____ Y N

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Please circle any of the follow conditions that you currently suffer from or have in the past:

Abnormal bleeding	Cancer	Hepatitis	Lung problems	Rheumatic Fever
Abnormal bruise	Diabetes	High blood pressure	Low Blood pressure	Sinusitis
Allergies	Dizziness	Hip replacement	Migraines	Stroke
Anemia	Epilepsy	HIV	Multiple Sclerosis	Swollen ankles
Arthritis	Fainting	Jaundice	Muscular Dystrophy	Thyroid disease
Asthma	Headaches	Knee replacement	Nervous tension	Tuberculosis
Blood disorders	Heart disease	Kidney disease	Psychiatric care	Ulcers
Breathlessness	Heart murmur	Liver disease	Radiation therapy	Venereal disease

Details about any of your circled answers:

_____

_____

Please identify any disease, condition or problem not listed:_____

_____

If you are currently using any medication or supplements, please list:

Medication_____Reason_____

Medication_____Reason_____

Medication_____Reason_____

Medication_____Reason_____

Are you allergic or have you reacted adversely to any of the following medications? (Please circle)

Aspirin	Nitrous Oxide	Valium	Dental Anesthetic (freezing)
Codeine	Erythromycin	Scopolamine	Ibuprofen
Demerol	Tetracycline	Penicillin	Sleeping Pills
Other antibiotics	Nembutal/Seconal	Latex	General Anesthetic

Others not listed:_____

POLICIES and CONSENT

- ☐ I hereby certify that the Medical and Dental History is accurate and complete to the best of my knowledge.
- ☐ I consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic or any drugs indicated.

Signature: _____Date: _____