NAME: _____
Title Last First Middle

(please print and complete both sides of this form)

Dr Yousif Chaaban
& Associates

Oxford Plaza
12603 - 153 Ave
Edmonton, Alberta
T5X 5X8

AHCIC NUMBER		DATE OF BIRTH Y M D	
ADDRESS		CITY	
PROVINCE	POSTAL CODE	HOME PHONE	
BUSINESS PHONE	OCCUPATION	AGE AT PRESENT	

DENTAL INSURANCE CO. / SELF	GROUP #	DENTAL INSURANCE CO. / SPOUSE	GROUP #
EMPLOYER	CERTIFICATE #	EMPLOYER / SPOUSE	CERTIFICATE #
SUPPL STAND	MEDICAL SERVICES CARD #	NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH Y M
FAMILY PHYSICIAN			PHONE #
PREVIOUS DENTIST			
REFERRED BY	DATE OF LAST MEDICAL EXAM Y M D	NAME & PHONE IN CASE OF EMERGENCY	

MEDICAL HISTORY

1) [ ] Yes [ ] No Have you been a patient in a hospital during the past two years?

2) [ ] Yes [ ] No Have you been under the care of a medical doctor during the past year?

3) [ ] Yes [ ] No Have you taken any medicine or drugs during the past two years?

4) [ ] Yes [ ] No Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any other drugs or medications?

5) [ ] Yes [ ] No Have you ever had any excessive bleeding requiring special treatment?

6) Check [✓] any of the following which you have had or have at present:

[ ] Heart Failure	[ ] Wheelchair Dependent	[ ] HIV
[ ] Heart Disease or Attack	[ ] Emphysema	[ ] Hepatitis A (Infectious)
[ ] Angina Pectoris	[ ] Cough	[ ] Hepatitis B (Serum)
[ ] High Blood Pressure	[ ] Tobacco Use	[ ] Liver Disease
[ ] Heart Murmur	[ ] Tuberculosis (TB)	[ ] Yellow Jaundice
[ ] Rheumatic Fever	[ ] Asthma	[ ] Blood Transfusion
[ ] Congenital Heart Defects	[ ] Hay Fever	[ ] Drug Addiction
[ ] Scarlet Fever	[ ] Sinus Trouble	[ ] Alcohol Abuse
[ ] Artificial Heart Valve	[ ] Allergies or Hives	[ ] Hemophilia
[ ] Heart Pacemaker	[ ] Diabetes	[ ] Venereal Disease (Syphilis,
[ ] Heart Surgery	[ ] Thyroid Disease	Gonorrhea)
[ ] Artificial Joint	[ ] Cancer, Leukemia	[ ] Cold Sores
[ ] Anemia	[ ] X-ray or Cobalt Treatment	[ ] Epilepsy or Seizures
[ ] Stroke	[ ] Chemotherapy	[ ] Fainting or Dizzy Spells
[ ] Kidney Trouble	[ ] Arthritis	[ ] Nervousness
[ ] Ulcers	[ ] Rheumatism	[ ] Psychiatric Treatment
[ ] Headaches	[ ] Cortisone / Steroid Medicine	[ ] Sickle Cell Trait / Disease
[ ] Mentally Handicapped	[ ] Glaucoma	[ ] Bruise Easily
[ ] Brain Injury	[ ] Pain in Jaw Joints	[ ] Multiple Sclerosis

7) [ ] Yes [ ] No Have you had an artificial implant – heart valve, hip replacement, pacemaker, etc.

8) [ ] Yes [ ] No When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired?

DO NOT WRITE IN THIS SPACE

9) [ ] Yes [ ] No Do your ankles swell during the day? _____

10) [ ] Yes [ ] No Have you lost or gained more than 10 pounds in the past year? _____

11) [ ] Yes [ ] No Do you ever wake up from sleep short of breath / or sweating heavily? _____

12) [ ] Yes [ ] No Are you on a special diet? Doctor's order or self-imposed? _____

13) [ ] Yes [ ] No Has your medical doctor ever said you have a cancer or tumor? _____

14) [ ] Yes [ ] No Do you have any disease(s), condition(s) or problem(s) not listed? _____

15) [ ] Yes [ ] No Women: a) Are you pregnant now? _____

b) Are you taking birth control pills? _____

c) Do you anticipate becoming pregnant? _____

_____

16) Please list all your current medications _____

_____

DENTAL HISTORY

1) [ ] Yes [ ] No Are you having dental discomfort at this time?

2) [ ] Yes [ ] No Do you feel very nervous about having dental treatment?

3) [ ] Yes [ ] No Have you ever had a bad experience in a dental office?

4) [ ] Yes [ ] No Do you have any other dental health concerns?

5) [ ] Yes [ ] No Do you think you have gum problems?

6) [ ] Yes [ ] No Do you notice popping, clicking or soreness of the jaw or just in front of your ears?

7) [ ] Yes [ ] No Are you involved in any contact sports? (i.e. hockey, football, boxing, basketball, etc.)

8) [ ] Yes [ ] No Do you brush daily?

9) [ ] Yes [ ] No Do you floss daily?

10) [ ] Yes [ ] No Have you ever had dental freezing (local anaesthetic) problems?

11) a. When was your last dental visit? _____

b. What was done? _____

c. When were your last dental x-rays taken? _____

d. Who was your last dentist? _____

12) a. Do you wear complete or partial dentures? _____

b. How many years have you worn dentures? _____

c. How old are your present dentures? _____

13) [ ] Yes [ ] No Are antibiotics required prior to dental treatment?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dental staff at the next appointment without fail.

DATE _____ PATIENT or GUARDIAN SIGNATURE _____ DENTIST SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

MEDICAL HISTORY/ PHYSICAL EVALUATION UPDATE

DATE	CHANGES	DATE	CHANGES

MEDICAL SUMMARY AB. PROPHY [ ] Absolute [ ] Relative

Dentist's Signature: