Bay Bloor Endodontics
60 Bloor St. W.,
Suite #409
Toronto,
M4W 3B8

Patient Medical Card

Name: _____
Address: _____
Date of Birth: _____
Referred By: _____

Phone Number: _____
Cell Number: _____
Physician: _____

General

Blood Pressure & Pulse (date & time)		
Are you under the care of a physician/psychiatrist for any medical or psychiatric condition ie. dementia, developmental delays?	Yes ○ No ○	
Are you now taking any pills or medication?	Yes ○ No ○	
Are you on any drugs for osteoporosis?	Yes ○ No ○	
Have you been on prednisone or any other steroids in the past 6 months?	Yes ○ No ○	
Do you have any conditions or therapies that could affect your immune system (leukemia, AIDS, HIV infection, radiotherapy, or chemotheraphy)?	Yes ○ No ○	
Have you ever been hospitalized? If yes, what for?	Yes ○ No ○	
Have you or any member of your immediate family had any complications from an anaesthetic such as pseudocholinesterase deficiency or malignant hyperthermia?	Yes ○ No ○	
Do you have heart disease? Have you ever have an MI or angina?	Yes ○ No ○	
Have you had high blood pressure?	Yes ○ No ○	
Do you have a bleeding tendency? If so, why?	Yes ○ No ○	
Have you had asthma or hay fever? Were you ever hospitalized for your asthma?	Yes ○ No ○	
Do you have sleep apnea?	Yes ○ No ○	
Do you have diabetes? If so, what type?	Yes ○ No ○	
Do you have any kidney disorders?	Yes ○ No ○	
Do you have any liver disorders? Have you ever had hepatitis?	Yes ○ No ○	
Have you ever had a stroke or a mini-stroke?	Yes ○ No ○	
Have you had problems with previous dental extractions?	Yes ○ No ○	
What is your height (Ft' Inches")/and Weight (Lbs)?		

Are you pregnant? If yes, how many months into pregnancy are you?	Yes ○ No ○	
Are you breast feeding?	Yes ○ No ○	
Do you drink alcohol? If yes, how much, and how often?	Yes ○ No ○	
Do you smoke? If yes, how much and for how long?	Yes ○ No ○	
Do you use recreational drugs such as marijuana or cocaine or other street drugs? When, what, and how much?	Yes ○ No ○	

Medical

When was the last time you saw your family physician?		
Are you allergic to any medications or foods? Latex, Penicillin?	Yes ○ No ○	
Are you taking any blood thinners? (anticoagulaants/ coumadin)	Yes ○ No ○	
Have you had heart murmur? If yes do you require antibiotics before dental work for it?	Yes ○ No ○	
Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (infective endocarditis), or a congenital heart defect?	Yes ○ No ○	

To the best of my knowledge, all of this information is correct.

Patient/Substitute Decision Maker:

Doctor:

Date:

Date: