

Last Updated:

Title	First Name test	Surname test
Health Card Number	Email	
Date of birth	Occupation	Employer
Address		Referred By
TORONTO Ontario Canada		Postal Code
Tel Contact		
.....		
Emergency Contact		Emergency Contact Number

Are you being treated for any medical conditions at the present time or have been treated within the last year?
Yes No Not Sure

If so, why? _____

When was your last medical check-up? _____

Have there been any changes in your general health in the last year?
Yes No Not Sure

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes No Not Sure

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes No Not Sure

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had an uncommon or adverse reaction to any medicines or injections?
Yes No Not Sure

If yes, please explain _____

Do you have or have you ever had asthma?
Yes No Not Sure

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?
Yes No Not Sure

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis),
a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes No Not Sure

Have you ever had hepatitis, jaundice or liver disease?
Yes No Not Sure

Which type of hepatitis? _____

Do you have a prosthetic or an artificial joint?
Yes No Not Sure

If yes, please explain _____

Do you have a bleeding problem or a bleeding disorder?
Yes No Not Sure

If yes, please explain _____

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Have you ever been hospitalized for any illness or operations?

Yes No Not Sure

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes No Not Sure

Do you have or have you ever had any of the following? Please Check

<input type="checkbox"/> AIDS	<input type="checkbox"/> Digestive Disorders / Acid Reflux	<input type="checkbox"/> Hypo/Hyperglycemia	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Drug / Alcohol Dependency	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Lupus	<input type="checkbox"/> Steroid Therapy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Head/Neck Injury	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis Medications (e.g. Fosamax, Actonel)	<input type="checkbox"/> Thrush
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Parkinsons Disease	<input type="checkbox"/> TMJ Disorder
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> HIV	<input type="checkbox"/> Radiation/Chemotherapy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Hodgkins Disease	<input type="checkbox"/> Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes No Not Sure

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes No Not Sure

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes No Not Sure

Are you nervous during dental treatment?

Yes No Not Sure

If yes, please explain _____

Email:

Dentist Dr. Maroulla Barsoum **Tel** (416) 703-7000

Address 215 Victoria St. Suite 100
TORONTO Ontario M5B 1T9 Canada

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The Information I have given above is true to the best of my knowledge

Patient Signature **Date**

PHIA permits us to collect and use your personal health information. In certain circumstances, PHIA also allows us to share it with others both inside and outside our organization. We do this for purposes such as:

- To provide you with health care;
- To get payment for your care which could include private insurers;
- To do health system planning and research;
- To report as required by law;

Unless you tell us not to, we can share your personal health information with any health care provider who has, is or will be providing you with health care. Members of your health care team are only allowed access to the information they need to give you the care you need. If you tell us not to share your information with a health care provider, we will not share your information unless permitted or required by law to do so. Please tell a member of your health care team if you do not want your information shared with a health care provider.