Dr. Shawn Higashi
NORTHLAND ORAL & MAXILLOFACIAL SURGERY CENTRE

patient registration & medical history questionnaire

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PATIENT: MR. / MISS / MRS. / MS. / DR. ❑ MALE ❑ FEMALE

NAME _____

DATE OF BIRTH (D/M/Y) _____ / _____ / _____ AGE _____

ADDRESS _____

_____ POSTAL CODE _____

HOME PHONE _____

CELL PHONE _____

OCCUPATION _____

BUSINESS PHONE _____

EMAIL _____

HEALTH CARD NUMBER (AHC) _____

REFERRING DOCTOR _____

FAMILY DENTIST _____

FAMILY PHYSICIAN _____

SPECIALIST _____

PERSON RESPONSIBLE FOR ACCOUNT _____

RELATIONSHIP TO PATIENT _____

NAME _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

_____

DATE OF BIRTH (D/M/Y) _____ / _____ / _____

EMPLOYER _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME _____

RELATIONSHIP _____

DAYTIME PHONE _____

CELL PHONE _____

The following information is required to enable us to provide you with the highest standard of care. All information is kept confidential. The doctor will review the questions and explain any that you do not understand. Please complete the entire form. If you need assistance, please notify one of our front desk team members and help will be provided.

HEIGHT _____ WEIGHT _____

Are you being treated for any medical condition at the present or have you been treated within the past year? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, why and who treated you? _____

When was your last medical checkup? _____

Has there been any change in your general health in the past year? If yes, please explain. ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you had any serious illnesses? If yes, please explain. ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you been hospitalized within the last 2 years?. ❑ Yes ❑ No ❑ Not sure/Maybe

Have you been out of Canada within the last 2 years? ❑ Yes ❑ No ❑ Not sure/Maybe

Are you taking any medication, non-prescription drugs or herbal supplements of any kind? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, please list (with dosage and frequency)_____

Do you have any allergies including medications, latex/rubber products, eggs/food etc? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, please list _____

Have you ever had an unexpected or adverse reaction to any medications, anesthetics or injections? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, please explain._____

Do you have or have you ever had asthma? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), or a heart condition from birth (e.g. congenital heart disease)? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you have a prosthetic or artificial joint? If yes, what year and what joint? ❑ Yes ❑ No ❑ Not sure/Maybe

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Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy? ❑ Yes ❑ No ❑ Not sure/Maybe

Have you ever had hepatitis, jaundice or liver disease? ❑ Yes ❑ No ❑ Not sure/Maybe

Are you taking any anticoagulation (blood thinner) medications? If so, what and when was your most recent INR? ❑ Yes ❑ No ❑ Not sure/Maybe

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Do you have a bleeding problem or bleeding disorder? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you have or have you ever had any of the following? Please check which apply:

❑ Chest pain/angina	❑ Rheumatic fever	❑ Pacemaker	❑ Corticosteroid therapy	❑ Seizure Disorder (epilepsy)
❑ Heart attack	❑ Bone, muscle or joint disorders	❑ Lung disease	❑ Diabetes	❑ Kidney disease
❑ Stroke	❑ Tuberculosis	❑ Stomach ulcers	❑ Thyroid disease	❑ Anxiety/Depression
❑ Heart murmur	❑ Cancer	❑ Arthritis	❑ Drug/alcohol dependency	❑ Osteoporosis medications (e.g. Fosamax, Actonel)
❑ Diet pill therapy	❑ High blood pressure	❑ Fainting spells	❑ Sleep Apnea/CPAP machine	
❑ Shortness of breath	❑ Can you easily walk up a flight of stairs ❑ Yes ❑ No			

Are there any conditions or diseases not listed above that you have or have had? If yes, please list. ❑ Yes ❑ No

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Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? If so, what? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you smoke or chew tobacco products? ❑ Yes ❑ No

If yes, how much? _____

Are you nervous during dental treatment? ❑ Yes ❑ No ❑ Not sure/Maybe

For women only: Are you pregnant or breast feeding? If pregnant, what is the expected delivery date? ❑ Yes ❑ No ❑ Not sure/Maybe

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Consent for the following: I hereby give consent for an examination, any necessary X-rays and/or any other necessary diagnostic procedures. I have read and understand the above information and have answered all questions to the best of my knowledge.

Signature _____ Date_____

Signature _____ Date_____