Dr. D. R. Jurasek Inc.

Office Phone: 250 833-1005
Home Phone: 250 804-9569
Email: Jurasek@shuswapdental.com

Medical History:

Please take the time to read and fill out this form to ensure your medical history is known prior to your appointment.

Patient Name: _____ Phone #: _____

If Patient is a minor, parent's or guardian's name: _____

Name of Family Doctor: _____

Date of Birth: (Month/Day/Year) _____/____/_____

Today's Date: (Month/Day/Year) _____/____/_____

Questions:

1. Are you in good health?..... ☐ Yes ☐ No

If no, please add details: _____

_____

_____

2. When was the last time you had a medical examination?..... Date: _____/____/_____
3. Are you presently receiving treatment for any illness?..... ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

4. Have you ever been hospitalized?..... ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

5. Have you had a heart attack in the last 6 months?..... ☐ Yes ☐ No

If yes, when?..... Date: _____/____/_____

6. Do you have a pacemaker?..... ☐ Yes ☐ No
7. Have you ever had Rheumatic Fever?..... ☐ Yes ☐ No

If yes, when?..... Date: _____/____/_____

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8. Have you ever been advised to take antibiotic pre-medication prior to dental treatment?..... ☐ Yes ☐ No

If yes, please specify: _____

_____

9. Do you have any heart circulatory problems?..... ☐ Yes ☐ No

10. Do you have any food allergies?..... ☐ Yes ☐ No

If yes, please specify: _____

_____

11. Do you have medication or latex allergies?..... ☐ Yes ☐ No

If yes, please specify: _____

_____

12. Do you have any other allergies?..... ☐ Yes ☐ No

If yes, please specify: _____

_____

13. Are you currently taking any kind of prescription medication, non-prescription medication, or vitamins?..... ☐ Yes ☐ No

If yes, please list and provide reason for medication: _____

_____

_____

_____

_____

_____

14. Have you ever had a reaction to any kind of medication or dental local anaesthetic?..... ☐ Yes ☐ No

If yes, please specify: _____

_____

15. Are you pregnant or think you may be pregnant?..... ☐ Yes ☐ No

16. Are you breastfeeding?..... ☐ Yes ☐ No

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17. For questions 18–38, please indicate if you currently have or have ever had any of the following:

18. Aids/HIV……..	☐ Yes	☐ No
19. Alcohol or chemical dependency……..	☐ Yes	☐ No
20. Arthritis or Rheumatism ……...	☐ Yes	☐ No
21. Artificial joints or valves …….	☐ Yes	☐ No
22. Asthma……..	☐ Yes	☐ No
23. Blood transfusion……..	☐ Yes	☐ No
24. Cancer/radiotherapy/chemotherapy……..	☐ Yes	☐ No
25. Diabetes……	☐ Yes	☐ No
26. Eating disorders……	☐ Yes	☐ No
27. Epilepsy/seizures……..	☐ Yes	☐ No
28. Fainting/dizzy spells…….	☐ Yes	☐ No
29. High/low blood pressure…….	☐ Yes	☐ No
30. Hyper/Hypo glycemia…….	☐ Yes	☐ No
31. Kidney disease……..	☐ Yes	☐ No
32. Liver disease (Hepatitis/Jaundice) …….	☐ Yes	☐ No
33. Lung disease/Chest pains……..	☐ Yes	☐ No
34. Mental or nervous disorder…….	☐ Yes	☐ No
35. Stomach ulcers……...	☐ Yes	☐ No
36. Stroke…….	☐ Yes	☐ No
37. Tuberculosis……...	☐ Yes	☐ No
38. Venereal/communicable disease…….	☐ Yes	☐ No

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39. Do you use tobacco, marijuana or vape? …….. ☐ Yes ☐ No

If yes, how much per day? _____ How much per week? _____

40. Do you consume alcohol? …….. ☐ Yes ☐ No

If yes, how much per day? _____ How much per week? _____

41. For questions 42-44, please indicate if you suffer from any of the following:

42. Headaches …….. ☐ Yes ☐ No

43. Earaches…….. ☐ Yes ☐ No

44. Neck Aches…….. ☐ Yes ☐ No

45. Please specify any additional information related to your health that was not addressed above:

_____

_____

_____

_____

_____

46. I, the undersigned, have completed the above questionnaire and/or update and that it is accurate to the best of my knowledge. I also certify that I consent to the performing of dental treatment and procedures agreed to be necessary or advisable. I also agree to assume responsibility for fees associated with those procedures. I understand that during the course of treatment, unexpected difficulties may arise, resulting in an altered prognosis, or a change of proposed treatment. I also consent to the taking of diagnostic photographs or radiographs agreed to be necessary. I also consent to be contacted by email.

After completing this form online, please save it to your computer and upload it at our website www.drjurasek.com or print it out and bring it in at your next appointment.

Signature of patient/guardian: _____