

Melbourne Dental Clinic

2100 Finch Ave W, Suite 204, North York, ON M3N 2Z9
Tel 416.736.9800 jmelbournedental.com

MEDICAL HISTORY

Please complete before your appointment

YOUR DETAILS

Full name

Date of birth

Email

Phone

If your personal information has changed in the past year, please note the changes below. If not, continue to the next section.

ADDRESS

Street address

City

Province

Postal code

YOUR PHYSICIAN AND PHARMACY

Family physician

Physician phone

Pharmacy

Pharmacy phone

EMERGENCY CONTACT

Emergency contact name and number

Relationship to you

YOUR HEALTH

Please answer as fully as you can. This affects how treatment is planned and which medications and anaesthetics are safe for you.

Are you currently under the care of a physician for any condition? Please describe.

List all medications you take, including over-the-counter medicines, vitamins and supplements.

List any allergies or reactions — to medications, latex, metals, foods or anaesthetics.

Have you had any surgery, hospital stay or serious illness? Please give approximate dates.

Are you pregnant or breastfeeding?

☐ Yes ☐ No

Do you smoke or use tobacco or vaping products?

☐ Yes ☐ No

Have you been advised to take antibiotics before dental treatment?

☐ Yes ☐ No

Is there anything else about your health you would like Dr. Melbourne to know?

DECLARATION

I confirm the above is accurate to the best of my knowledge and I will inform the clinic of any change in my health or medication.

Signature

Date (dd/mm/yyyy)