STRATFORD DENTAL
DR. MARK STRAUS, D.D.S.

3035 Ontario Street
Stratford, Ont. N5A 6S5
Phone: 519-273-0580

Medical History

Medical Alert (Office Use Only)

Name _____

Address _____ City _____ Postal Code _____

Phone (Home) _____ (Cell) _____ Sex M ___ F ___ Age _____ Birth Date _____

Adult Patient

Occupation _____

Employer _____

Phone (Work) _____

Email _____

Child Patient

Mother's Name _____

Employer _____ Phone (wk) _____

Father's Name _____

Employer _____ Phone (wk) _____

Person responsible for account _____

Emergency Contact Name _____ Phone # _____

Dental Insurance No ☐ Yes ☐ Plan _____ Group# _____ Cert/Id# _____

1. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If Yes, for what? _____

Physician's name _____ Phone _____

2. Are you currently taking any medications? Yes ☐ No ☐

If yes, please list the name and dosage _____

_____

3. Allergies/reaction to medication or other allergies? Please list _____

_____

4. Have you been hospitalized in the past five years? Yes ☐ No ☐ **If YES Specify** _____

5. Indicate which of the following you have had, or presently have

Heart (Surgery, Disease, Attack)	Yes ☐ No ☐	Latex Sensitivity	Yes ☐ No ☐	Autism	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Stomach Ulcers	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Congenital Heart Disease	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Yellow Jaundice	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	A.I.D.S.	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	H.I.V. Positive	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Arthritis/Rheumatism	Yes ☐ No ☐	Kidney Trouble	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Cortisone Medicine	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐	Bruise Easily	Yes ☐ No ☐
Diet (Special/Restricted)	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐	Neurological Disorders	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Tumors	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Artificial Joints (hip/knee etc)	Yes ☐ No ☐	Do You Smoke	Yes ☐ No ☐	Nervous/Anxious	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	Fainting or Dizzy Spells	Yes ☐ No ☐	Psychiatric/Psychological Care	Yes ☐ No ☐

6. Do You have, or have you had any disease, or problems not listed? Yes ☐ No ☐

If yes, please list _____

7. Women Are you: **Pregnant?** Yes ☐ _____ Months No ☐ **Nursing** Yes ☐ No ☐ **Taking Birth Control Pills** Yes ☐ No ☐

Medical Doctor: _____ **Phone:** _____

Signature: _____ **Date:** _____