



**Medical / Surgical History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Care Card# \_\_\_\_\_

**Preferred method of contact:** \_\_\_\_\_

Please indicate which Procedure(s) you would like to discuss with Dr. Mosher:

It is important that we are aware of your general health and medical background. In some instances this can critically affect what procedures we can safely undertake on you and under what circumstances. This information will be kept confidential. Please assist Dr. Mosher by completing the following information:

**Do You Have?**

<b>CARDIOVASCULAR</b>	<b>Yes</b>	<b>No</b>
• Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>
• History of Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
• Stroke	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
• High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
• Irregular Pulse/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
• Do you take blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you take antibiotics before Dental work?	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>RESPIRATORY</b>	<b>Yes</b>	<b>No</b>
• Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
• Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
• Short of breath easily	<input type="checkbox"/>	<input type="checkbox"/>
• Productive Cough	<input type="checkbox"/>	<input type="checkbox"/>
• Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you quit smoking? If YES please specify when _____	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>RENAL</b>	<b>Yes</b>	<b>No</b>
• Kidney problems/failure	<input type="checkbox"/>	<input type="checkbox"/>
• Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>GASTROINTESTINAL</b>	<b>Yes</b>	<b>No</b>
• Heartburn/Hiatus Hernia	<input type="checkbox"/>	<input type="checkbox"/>
• Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
• History of Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>OTHER</b>	<b>Yes</b>	<b>No</b>
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
• Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
• Anemia	<input type="checkbox"/>	<input type="checkbox"/>
• Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
• Leg blood clots	<input type="checkbox"/>	<input type="checkbox"/>
• Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
• Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
• Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>
• Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER**

	<b>Yes</b>	<b>No</b>
• Blackouts/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
• HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
• Tumours/Malignancy	<input type="checkbox"/>	<input type="checkbox"/>
• Possibility of Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
• Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
• Dentures/Bridgework	<input type="checkbox"/>	<input type="checkbox"/>
• Do you drink more than one alcoholic drink each day?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever injected street drugs?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you take medications? If yes please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have allergies to medications, latex or tape? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
• Have you or your family members had problems with anesthesia? If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have any other Medical Problems that we should be aware of? _____	<input type="checkbox"/>	<input type="checkbox"/>
• Height: _____ Weight: _____		

If you answered yes to any of the above questions, please give details here:

**Please list all Previous Surgeries:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_