Dr. Matthew Foulkes

#301 1842 Oak Bay Avenue, Victoria, BC V8R 1C2
(250) 598 - 5441

Mr./Mrs./Ms./Miss./Dr._____
Date of Birth (mm/dd/yy)_____
Home Address _____
Phone: h)_____ c) _____
E-mail _____
Employer_____
Occupation _____
Whom may we thank for referring you to us?

_____

HEALTH HISTORY

Who is your current personal family physician?

_____

Are you being treated for any medical condition at the present or have you been treated within the last year? _____
If so,why? _____
When was your last medical check-up?_____
Have you ever been hospitalized for any illness or operations?

_____

Are you currently taking any medications, non-prescription drugs or herbal supplements? _____
Do you have any allergies?_____
Have you ever had any peculiar or adverse reactions or injections?

_____

Have you ever:
Fainted? YES☐ NO☐
Experienced shortness of breath? YES☐ NO☐
Experienced chest pain? YES☐ NO☐
Had injury/surgery/radiation therapy to your face? Jaw?
Head or neck? YES☐ NO☐
Had a general anesthetic? YES☐ NO☐
Do you get frequent migranes/headaches? YES☐ NO☐
Do you have or have you ever had any heart or blood pressure problems? YES☐ NO☐
Had a replacement or repair of a heart valve, and infection of the heart, heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES☐ NO☐
Do you have a prosthetic or artificial joint? YES☐ NO☐
Do you have a bleeding problem or bleeding disorder? YES☐ NO☐

Do you have any of the following?

☐Alzheimers	☐Angina	☐Anemia
☐Arthritis	☐Cancer	☐Diabetes (Type 1/2)
☐Drug/Alchl Dependency	☐Emphysema	☐Epilepsy/Seizures
☐Fibromyalgia	☐Heart Attack	☐Hodgkins Disease
☐Hypo/hyperglycemia	☐Kidney Disease	☐Lung Disease
☐Lupus	☐Parkinsons Disease	☐Rheumatic Fever
☐Sexual Transmitted Infctn	☐Steroid Therapy	☐Stomach Ulcers
☐Stroke	☐Thyroid Disorder	☐Tuberculosis

Are there any conditions or disease not listed above that you have or have had? YES☐ NO☐
If yes, please list. _____
Are there any diseases or medical conditions that run in your family (i.e. diabetes, cancer, heart disease)? YES☐ NO☐
If yes, please list. _____
Do you smoke or chew tobacco products? YES☐ NO☐

DENTAL HISTORY

When was your last dental visit? _____
Who is your previous dentist? _____
When did you last have dental x-rays taken? _____
Have you ever been advised to take antibiotics before dental appointments? _____
Have your tooth/teeth ache lately? If so, for how long? _____
Are your teeth sensitive? If so, in which area(s)? _____
Do you gums bleed when you brush or floss your teeth? _____
Do you have any pain when you chew? _____
Do you feel you have bad breath? _____
Have you ever been in a vehicle accident or experienced any blows to your jaw? _____
Have you ever had any implant surgery in your jaw or either jaw joints? If so, who performed the surgery and when was it done?

_____

_____

Are you being followed-up by a dental specialist? _____
Please list anything not mentioned above regarding your past dental history? _____

_____

Do you have dental insurance? YES☐ NO☐

Dental Insurance (for office use only)
Insurance name _____
Group _____
Certificate _____
% A ____ B ____ C ____
Deductions _____
Recall Freq_____
BW's/Pan Freq _____
Limits_____

The information I provided above is true to the best of my knowledge, and I will assume responsibility for fees associated with any dental procedures completed at Dr. M. Foulkes' dental office.

_____
Parental/Patient Signature

_____
Date