DR. MATTHEW FOULKES

■Stroke

☐Thyroid Disorder

■Tuberculosis

Date

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

			Are there any diseases or medical conditions that	
			run in your family (i.e. diabetes, cancer, heart disease)? YES \mathbf{O} NO \mathbf{O}
Mr./Mrs./Mss./Dr			If yes, please list	
Date of Birth (mm/dd/yy)			Do you smoke or chew tobacco products?	YES O NO O
Home Address				
Phone: h)	c)			
E-mail			DENTAL HISTORY	
Employer			When was your last dental visit?	
Occupation			Who is your previous dentist?	
Whom may we thank for referring you to us?			When did you last have dental x-rays taken? Have you ever been advised to take antibiotics before dental	
HEALTH HISTORY			appointments?	
Who is your current personal family physician?			Are your teeth sensitive? If so, in which area(s)?	
			Do you gums bleed when you brush or floss your teeth?	
Are you being treated	for any medical conditi	ion at the present or	Do you have any pain when you chew?	
-	•		Do you feel you have bad breath?	
have you been treated within the last year?			Have you ever been in a vehicle accident or experienced any	
When was your last medical check-up?			blows to your jaw?	
Have you ever been hospitalized for any illness or operations?			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?	
or herbal supplements?			Are you being followed-up by a dental specialist?	
Have you ever had any peculiar or adverse reactions or injections?			Please list anything not mentioned above regarding your past	
riave you ever riad arry	peculial of adverse rea	actions of injections:	dental history?	
Have you ever:			,	
Fainted?		YES O NO O	Do you have dental insurance?	YES NO
Experienced shortness of breath?		YESO NOO	•	
Experienced chest pain?		YESO NOO		
Had injury/surgery/radiation therapy to your face? Jaw?			Dental Insurance (for office use only)	
		YES NO	Insurance name	
Had a general anesthetic?		YES NO	Group	
Do you get frequent migranes/headaches? YESO NOO			Certificate	
Do you have or have you ever had any heart or			% A B C	
blood pressure problems?			Deductions	
Had a replacement or repair of a heart valve, and			Recall Freq	
infection of the heart, heart condition from birth			BW's/Pan Freq	
(i.e. congenital heart di			Limits	
Do you have a prosthe		YESO NOO		
Do you have a bleeding	•			
			The information I provided above is true to the best of n	ıy
Do you have any of the following? □Alzheimers □Angina □Anemia		knowledge, and I will assume responsibility for fees associated with		
□ Arthritis	□Cancer	□Diabetes (Type 1/2)	any dental procedures completed at Dr. M. Foulkes' dental office.	
□Drug/Alchl Dependency	□Emphysema	☐Epilepsy/Seizures		
□Fibromyalgia	☐Heart Attack	☐Hodgkins Disease		
☐Hypo/hyperglycemia	☐Kidney Disease	☐Lung Disease		
□Lupus □Parkinsons Disease □Rheumatic Fever		Parental/Patient Signature		
☐Sexual Transmitted Infctn		☐Stomach Ulcers		
-Sekuai Hansiilittea IIIICtii	- steroid merapy			

Are there any conditions or disease not listed

YESO NOO

above that you have or have had?

If yes, please list.