



Dr. Elisabeth Specht  
 BScPT, DDS, FAAHD  
 General Dentist  
 Preferred Area of Practice:  
 Dental Surgery & Sedation

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ (dd.mm.yyyy)

Family Physician: \_\_\_\_\_ Pharmacy Name/Town: \_\_\_\_\_

Do you wish to discuss **options** for **SEDATION**?  YES  NO Height: \_\_\_\_\_ Weight \_\_\_\_\_

List all **MEDICATIONS** (incl. Over the Counter Medications, Vitamins and Herbal Products) \_\_\_\_\_

List **ALLERGIES** & Medications that you should **NOT** take: \_\_\_\_\_

List all **HOSPITALIZATIONS & SURGERIES** \_\_\_\_\_

List all **SPECIALISTS** that you have seen in the last 5 years:

REASON

DOCTOR'S NAME

Have you EVER had medical issues with the following:

	YES	NO		YES	NO
<b>Eyes</b>	<input type="radio"/>	<input type="radio"/>	<b>High Blood Pressure</b>	<input type="radio"/>	<input type="radio"/>
<b>Thyroid Gland</b>	<input type="radio"/>	<input type="radio"/>	<b>Bleeding Disorders</b>	<input type="radio"/>	<input type="radio"/>
<b>Heart</b>	<input type="radio"/>	<input type="radio"/>	<b>Diabetes</b>	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	insulin-controlled?	<input type="radio"/>	<input type="radio"/>
Chest Pain/Angina	<input type="radio"/>	<input type="radio"/>	Last HbA1C value?		
Pacemaker/Stent/Valve Replacement	<input type="radio"/>	<input type="radio"/>	<b>Brain/Neurological Disorder</b>	<input type="radio"/>	<input type="radio"/>
Other Heart Concern	<input type="radio"/>	<input type="radio"/>	Mental Health Condition	<input type="radio"/>	<input type="radio"/>
<b>Lungs</b> (e.g. COPD, Asthma, CF)	<input type="radio"/>	<input type="radio"/>	Stroke/TIA	<input type="radio"/>	<input type="radio"/>
Use home oxygen?	<input type="radio"/>	<input type="radio"/>	Epilepsy/Seizure Disorder	<input type="radio"/>	<input type="radio"/>
<b>Stomach</b> (e.g. heartburn)	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
<b>Liver</b> Disease or Hepatitis	<input type="radio"/>	<input type="radio"/>	<b>Sleep Apnea or Chronic Snoring</b>	<input type="radio"/>	<input type="radio"/>
<b>Intestines</b> (e.g. Crohn's, Celiac)	<input type="radio"/>	<input type="radio"/>	Use CPAP Machine	<input type="radio"/>	<input type="radio"/>
<b>Kidneys</b>	<input type="radio"/>	<input type="radio"/>	<b>Infectious Disease?</b> (e.g.HIV, MRSA)	<input type="radio"/>	<input type="radio"/>
<b>Bone or Muscle Disease?</b>	<input type="radio"/>	<input type="radio"/>	<b>Pregnant or breastfeeding?</b>	<input type="radio"/>	<input type="radio"/>
<b>Autoimmune Disorder</b>	<input type="radio"/>	<input type="radio"/>	Do you <b>smoke/vape</b> ?	<input type="radio"/>	<input type="radio"/>
<b>Cancer</b>	<input type="radio"/>	<input type="radio"/>	<b>Recreational Drug Use?</b>	<input type="radio"/>	<input type="radio"/>
			<b>Other medical concerns</b>	<input type="radio"/>	<input type="radio"/>

I, \_\_\_\_\_ have completed this medical questionnaire truthfully and to the best of my ability. I understand that failure to disclose any medical information can have dangerous and potentially fatal effects on the outcome of my treatment.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date