MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR. MISS. MRS. MS. DR.

DATE OF BIRTH (DAY/MONTH/YEAR:) / /

ADDRESS HOME:

PHONE:

EMAIL:

CELL #:

BUSINESS:

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALTY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALTY:

PHONE OR ADDRESS:

SIN#: _____ _____ _____

PRIMARY INSURANCE

Ins. Company: _____ Tel (_____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy #: _____ Certificate #: _____ ID/SIN#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

SECONDARY INSURANCE

Ins. Company: _____ Tel (_____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy #: _____ Certificate #: _____ ID/SIN#: _____

Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non prescription drugs or herbal supplements of any kind? If yes, please list.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:
☐ YES ☐ NO ☐ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other eg. hayfever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Do you have any conditions or therapies that could affect your immune systems
eg. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Have you ever had hepatitis, jaundice or liver disease?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE

16. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures (epliepsy)	☐ drug/alcohol dependency
☐ heart attack		☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ prosthetic heart valve	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
		☐ cancer	☐ arthritis	☐ diet pill therapy	

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Are there any diseases or medical problems that run in your family?
(eg. diabetes, cancer or heart disease)
☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Do you smoke or chew tobacco products?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Are you nervous during dental treatments?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

DENTAL HISTORY

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____

2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other _____

3. When was your last dental visit? _____ Last X-Ray _____

4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____

5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____

	YES	NO
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never		
7. Do you gums feel swollen or tender?	☐	☐
8. Do you have bad breath or a bad taste in your mouth?	☐	☐
9. Do your jaws crack, pop or grate when you open widely?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you have food catch between your teeth?	☐	☐
12. Have you ever had local anaesthetic (freezing)?	☐	☐
Any Complications? ☐ Yes ☐ No Specify _____	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify _____	☐	☐

14. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal

15. Are you satisfied with the appearance of your teeth? Specify _____	☐	☐

GENERAL RELEASE: I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. **To the best of my knowledge, the above information is correct.**

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES