720 Guelph Line, Suite 103, Burlington, ON L7R 4E2
Phone: 905-633-8328 | info@endoburlington.ca
www.endoburlington.ca

Burlington Endodontics

Medical History Questionnaire

Prefix: Last Name: First Name:

Emergency Contact Name: Emergency Contact #:

Referring Dentist: Family Physician:

1. Are you being treated for any medical condition at present or within the past year? ..... ◯ Yes ◯ No ◯ Maybe

If yes, please explain:

2. Are you allergic to any medications, latex or rubber products? ..... ◯ Yes ◯ No ◯ Maybe

If yes, please list them:

3. Please list any medications or non-prescription drugs (including supplements) that you are taking:

4. Have you ever had a peculiar or adverse reaction to medication or injections? ..... ◯ Yes ◯ No ◯ Maybe

5. Do you have or have you ever had asthma? ..... ◯ Yes ◯ No ◯ Maybe

6. Do you have or have you ever had any heart or blood pressure problems? ..... ◯ Yes ◯ No ◯ Maybe

7. Do you have a prosthetic or artificial joint? ..... ◯ Yes ◯ No ◯ Maybe

8. Do you have any conditions or therapies that could affect your immune system (eg leukemia, chemotherapy, HIV)? ..... ◯ Yes ◯ No ◯ Maybe

9. Have you had hepatitis, jaundice or liver disease? ..... ◯ Yes ◯ No ◯ Maybe

10. Do you have a bleeding problem or bleeding disorder? ..... ◯ Yes ◯ No ◯ Maybe

11. Do you have, or have ever had any of the following?

◯ Stroke/TIA ◯ chest pain/angina ◯ heart attack
◯ heart surgery ◯ heart murmur ◯ pacemaker ◯ mitral valve prolapse ◯ tuberculosis ◯ lung disease
◯ stomach ulcers ◯ arthritis ◯ steroid therapy ◯ high blood pressure ◯ HIV/AIDS ◯ rheumatic fever
◯ liver disease ◯ diabetes ◯ kidney disease ◯ epilepsy ◯ asthma ◯ nervous disorder
◯ artificial joints ◯ cancer ◯ thyroid disease ◯ osteoporosis ◯ drug/alcohol/cannabis use or dependency

12. Are there any conditions/diseases not listed above that you have, or have ever had? ..... ◯ Yes ◯ No ◯ Maybe

If yes, please list them:

13. Female patients: Are you breast feeding or pregnant? ..... ◯ Yes ◯ No ◯ Maybe

The above information is correct to the best of my knowledge.

Patients/Guardian Signature: Date:

Dentist Signature: Date: