BROADWAY DENTAL CLINIC
640 BROADWAY, WINNIPEG, MB R3C 0X3
(204) 772-3523
SERVING DOWNTOWN WINNIPEG SINCE 1995

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Personal Health History

Name: ☐ M ☐ F **DOB (MM/DD/YY):**

Address: **City:** **Prov:** **Postal:**

CELL: **WORK:** **HOME:**

EMAIL: **EMPLOYER:**

Personal Physician: **Physician Phone #:**

Dental Insurance Company

Name:
Policy Holder Name:
DOB (MM/DD/YY):
Policy/Plan #:
Certificate/Id #:

If Under 18

Parent or Guardians Name:
DOB (MM/DD/YY):

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of treatment. All information will be kept strictly confidential.

1. Are you under the care of a physician? If so, for what condition?
2. Have you been hospitalized in the last 2 years? If so, please explain
3. Are you taking any drugs or medications? If so, please list
4. Do you have any allergies? If so, please list
5. Have you had adverse reactions to any drug, local anesthesia, antibiotics, barbiturates, sedatives or pain killers?

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6. Tick any of the following that you have had:

AIDS/HIV ☐	Digestive disorders ☐	Kidney disease ☐	STI ☐
Anemia ☐	Drug/alcohol dependency ☐	Lung disease ☐	Sleep apnea ☐
Angina ☐	Emphysema ☐	Lupus ☐	Steroid therapy ☐
Arthritis ☐	Epilepsy [Seizures] ☐	Migraines ☐	Stomach ulcers ☐
Asthma ☐	Fibromyalgia ☐	Mitral valve prolapses ☐	Stroke ☐
Blood transfusion ☐	Heart trouble ☐	Osteoporosis ☐	Thyroid disorder ☐
Cancer ☐	Hepatitis AIBIC ☐	Pacemaker ☐	Tuberculosis (TB) ☐
Cold sores ☐	High/low blood pressure ☐	Radiation/Chemotherapy ☐	Are you a smoker: Y ☐ N ☐
Diabetes: Type 1 ☐ 2 ☐	Hypo/ Hyperglycemia ☐	Rheumatic fever ☐	Other: ☐

7. Have you ever had abnormal bleeding associated with previous surgery, trauma or extractions?

8. Are you pregnant?

9. What dental conditions concern you at present?

10. How did you find out about our office?

This is to certify that I, the undersigned, consent to the dental procedures agreed to be necessary or advisable and will assume responsibility for fees associated with those procedures.

Patient OR Parent/Guardian Signature Date

Please be assured that your personal information is for office use and will only be used following PHIA