Medical & Dental History Questionnaire

Title: Mr. Mrs. Ms. Mst. Miss. Dr.

Name:_____
(first) (last) (initial)
Nick Name:_____
Date of Birth (D/M/Y):_____

Home Address:_____

Suite:_____City:._____Prov.____ Postal Code_____

☐Home Phone:_____

☐Cellular Phone:_____

☐Business Phone:_____

☐Email:_____

Please check preferred method of contact above

Occupation:_____

Name of guardian/parents:_____
(if under 18 or under guardianship)
Address (if not same as above):_____

_____

Phone: (if not same as above):_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name:_____

Relationship:_____
Phone:_____

(1)Name of family doctor:_____

Phone or address:_____

(2)Name of specialist:_____

Phone or address:_____

Pharmacy Name/Number:_____

~~Driver's License number:~~_____

~~OHIP number:~~_____

Do you have dental insurance? ☐Yes ☐No

Employer:_____

Primary Ins. Policy #/Cert.#:_____

Secondary Ins. Policy#/Cert.#:_____

How did you hear about our office?_____

MEDICAL HISTORY: 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. 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 been treated within the past year? If so, why?

☐Yes ☐No ☐Maybe/Not Sure _____

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 ☐Maybe/Not Sure

_____

4.Are you taking any medications, non-prescription drugs, natural supplements of any kind? If yes please list with doses or provide list.

☐Yes ☐No ☐Maybe/Not Sure _____

5.Do you have any allergies ? If yes please list below ☐Yes ☐No ☐Maybe/Not Sure

a) medications:_____

b) latex / rubber products/ metals:_____

c) Other (eg. hayfever, foods, dyes):_____

6.Have you ever had a peculiar or adverse reaction to any medications or injections? ☐Yes ☐No ☐Maybe/Not Sure

If yes, please explain:_____

7.Do you have or ever had asthma?_____ ☐Yes ☐No ☐Maybe/Not Sure

8.Do you have or ever had any heart or blood pressure problems?_____ ☐Yes ☐No ☐Maybe/Not Sure

9.Do you have or ever had a replacement or repair of a heart valve, infection of the heart (infective endocarditis), a heart condition from birth (congenital heart disease) or a heart transplant?_____☐Yes ☐No ☐Maybe/Not Sure

10.Do you have a prosthetic or artificial joint? (i.e. knee or hip?)_____ Yes No Maybe/Not Sure

11.Do you have any condition or therapies that could affect your immune system? (i.e. chemotherapy, radiotherapy, leukemia, AIDS/HIV infection)

_____ Yes No Maybe/Not Sure

12. Have you ever had hepatitis, jaundice (other than birth) or liver disease?_____ Yes No Maybe/Not Sure

13. Do you have a bleeding problem or bleeding disorder?_____ Yes No Maybe/Not Sure

14. Have you ever been hospitalized for any illness? Or had any surgeries? If Yes please explain Yes No Maybe/Not Sure

_____

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

Chest pain, angina	rheumatic fever	lung disease	stomach ulcers	Drug/alcohol dependency
Heart attack	mitral valve	tuberculosis	arthritis	osteoporosis medications
stroke	prolapse	cancer	seizure(epilepsy)	(e.g.Fosamax, Actonel)
shortness of breath	heart murmur	steroid therapy	kidney disease	pace maker
diabetes	thyroid disease	organ transplant	malignant hypothermia	mental health disorder

16.Are there any conditions or diseases not listed above that you have or have had? If so, what?_____

_____

17. Are there any diseases that run in your family (e.g. diabetes, cancer, heart disease)

Yes No Maybe/NotSure_____

18.Do you smoke /use tobacco/marijuana products? Yes No If yes, how much per day? _____How many years?_____

FOR WOMEN ONLY:

1.Are you pregnant? Yes No Maybe/Not Sure Expected delivery date?_____

2. Are you breast feeding? Yes No

3. Are you on birth control pills? Yes No

_____

DENTAL HISTORY

1.When was your last dental visit?_____2. When was your last cleaning?_____

3.Who was your previous dentist?_____4. Did you have xrays taken within the last 2 years? Yes No

5.How would you describe your dental health at present?_____ Good Fair Poor

6.What are your present dental concerns, if any?

Bleeding Gums Crooked teeth Cosmetic Loose Teeth Bad Breath Food trapping Sensitive Teeth

Toothache Loose Dentures Missing teeth/spaces want whiter teeth Other:_____

7. Are you dissatisfied with the appearance of your teeth? _____ Yes No Maybe/Not Sure

8. Any teeth extracted due to accident, decay or gum disease? Yes No Maybe/Not Sure

If yes please explain_____

9.Have you ever had complications after extractions?_____ Yes No Maybe/Not Sure

10.Do you use any of the following as part of your oral hygiene regiment?

electric toothbrush floss softpics proxybrush stimudent flosswand toothpick rubbertip

waterpic fluoride rinse/tablet fluoridated toothpaste natural toothpaste prevident toothpaste

other(s):_____

11. Are you anxious during dental visits?_____ Yes No Maybe/Not Sure

12.Do you think you might like to have your dental treatment done with sedation?_____ Yes No Maybe/Not Sure

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume full responsibility of the fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

X_____ date:_____

Signature , (parent or guardian if under 18 years old)