

# Medical History Questionnaire

## MEDICAL ALERT:

NAME: MR./MISS./MRS./MS./DR. \_\_\_\_\_

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

ADDRESS (HOME): \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_

Do you have dental coverage Y N  
Your dental insurance is private we do NOT  
have access to what you are covered for.  
\*IF you are unaware please ask for an estimate to  
be sent to be sent or contact your insurance provider.  
Our fees are in accordance with the Ontario Dental  
Association's current suggested fee guide.

## IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

DAY-TIME PHONE: \_\_\_\_\_

NAME OF FAMILY DOCTOR: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

(1) NAME OF MEDICAL SPECIALIST: \_\_\_\_\_

## PLEASE READ and initial

The account is the responsibility of the patient/parent  
Payment is due at time of treatment  
We require 2 business days to reschedule appointments  
Short notice cancellations could result in a \$25 fee

**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 currently being treated for any medical condition or have you been treated within the past year? If yes, please explain?  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 them.  
 Yes  No  Not Sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below:  Yes  No  Not Sure/Maybe

a) medications \_\_\_\_\_

b) latex/rubber products \_\_\_\_\_

c) other (e.g. hay fever, seasonal/environmental, 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 replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?  
 Yes  No  Not Sure/Maybe

10. Do you have a prosthetic or artificial joint?  Yes  No  Not Sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?  Yes  No  Not Sure/Maybe

12. Have you ever had hepatitis, jaundice or liver disease?  Yes  No  Not Sure/Maybe

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

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  
 Yes  No  Not Sure/Maybe

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

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> rheumatic fever       | <input type="checkbox"/> pacemaker      | <input type="checkbox"/> steroid therapy                         | <input type="checkbox"/> seizures (epilepsy)                              |
| <input type="checkbox"/> heart attack       | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease   | <input type="checkbox"/> diabetes                                | <input type="checkbox"/> kidney disease                                   |
| <input type="checkbox"/> stroke, TIA        | <input type="checkbox"/> tuberculosis          | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease                         | <input type="checkbox"/> shortness of breath                              |
| <input type="checkbox"/> heart murmur       | <input type="checkbox"/> cancer                | <input type="checkbox"/> arthritis      | <input type="checkbox"/> drug/alcohol/cannabis use or dependency | <input type="checkbox"/> osteoporosis medications (e.g. Fosamax, Actonel) |

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.  
 Yes  No  Not Sure/Maybe

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17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?  
 Yes  No  Not Sure/Maybe

18. Do you smoke or chew tobacco products?  Yes  No  Not Sure/Maybe

19. Are you nervous during dental treatment?  Yes  No  Not Sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?  
 Yes  No  Not Sure/Maybe

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21. Do you identify as a patient with a disability? If yes, please explain.  Yes  No  Not Sure/Maybe

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**To the best of my knowledge, the above information is correct:**

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DENTIST'S NOTES: