Medical History Questionnaire

MEDICAL ALERT:

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

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

ADDRESS: CITY: POSTAL CODE:

PHONE:

EMAIL:

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 DOCTOR:

AREA OF SPECIALITY:

PHONE AND ADDRESS:

(2) NAME OF PHARMACY:

PHONE AND ADDRESS:

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.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke, TIA	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ shortness of breath
☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol/cannabis use or dependency	☐ 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:

DENTAL HISTORY

1. When was your last dental visit? _____

2. When did you last have dental x-rays? _____

3. How often do you brush your teeth? _____

4. How often do you floss your teeth? _____

5. Have you been seeing a dentist regularly? ○ Yes ○ No

6. Do any of your teeth ache? ○ Yes ○ No

7. Have you ever been advised to take antibiotics before dental treatment? ○ Yes ○ No

8. Do your gums bleed when you brush? ○ Yes ○ No

9. Do you have any pain when you chew? ○ Yes ○ No

10. Do you feel that you have bad breath? ○ Yes ○ No

11. Have you ever been in a vehicle accident or experienced any blows to your jaw? ○ Yes ○ No

12. Have you ever had any implant surgery in one or both of your jaws or jaw joints? ○ Yes ○ No

13. If you answered yes to the last question, who performed the surgery and when? _____

14. Please list anything else not mentioned regarding your past dental history? _____

_____

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

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTIST'S NOTES: