

Medical & Dental History Questionnaire

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Legal Name: _____	Name: _____
Preferred Name: _____	Relationship: _____
Pronouns: _____	Phone: _____
Sex assigned at birth: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	(1) Name of family doctor: _____
Date of Birth (D/M/Y): _____	Phone or address: _____
Home Address: _____	(2) Name of specialist: _____
Suite: _____ City: _____ Prov. _____ Postal Code _____	Phone or address: _____
<input type="checkbox"/> Home Phone: _____	Pharmacy Name/Number: _____
<input type="checkbox"/> Cellular Phone: _____	Driver's License number: _____
<input type="checkbox"/> Business Phone: _____	Health Card number: _____
<input type="checkbox"/> Email: _____	Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please check preferred method of contact above	Employer: _____
Occupation: _____	Primary Ins. Policy #/Cert.#: _____
Name of guardian/parents: _____	Secondary Ins. Policy#/Cert.#: _____
(if under 18 or under guardianship)	How did you hear about our office? _____
Address (if not same as above): _____	
Phone: (if not same as above): _____	

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.

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Chest pain, angina | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> lung disease | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> Drug/alcohol dependency |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> mitral valve | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> arthritis | <input type="checkbox"/> osteoporosis medications |
| <input type="checkbox"/> stroke | <input type="checkbox"/> prolapse | <input type="checkbox"/> cancer | <input type="checkbox"/> seizure(epilepsy) | (e.g.Fosamax, Actonel) |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart murmur | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> kidney disease | <input type="checkbox"/> pace maker |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> organ transplant | <input type="checkbox"/> malignant hypothermia | <input type="checkbox"/> 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/Not Sure _____

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?
- | | | | | | | |
|--|---|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Cosmetic | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food trapping | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Loose Dentures | <input type="checkbox"/> Missing teeth/spaces | <input type="checkbox"/> 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?
- | | | | | | | | |
|--|--|---|---|---|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> electric toothbrush | <input type="checkbox"/> floss | <input type="checkbox"/> softpics | <input type="checkbox"/> proxybrush | <input type="checkbox"/> stimudent | <input type="checkbox"/> flosswand | <input type="checkbox"/> toothpick | <input type="checkbox"/> rubbertip |
| <input type="checkbox"/> waterpic | <input type="checkbox"/> fluoride rinse/tablet | <input type="checkbox"/> fluoridated toothpaste | <input type="checkbox"/> natural toothpaste | <input type="checkbox"/> 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)