

# Medical & Dental History Questionnaire

## IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

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