MEDICAL AND DENTAL HISTORY

Name:_____ D.O.B._____

Address:_____Unit Number:_____

City:_____Postal Code:_____

Email address:_____

Phone: Home:_____Work:_____Cell:_____

MEDICAL

1. Are you being treated for any medical conditions at the present or have you been treated within two years? ☐ YES ☐ NO
   If yes, explain:_____
   Family Physican:_____Phone #_____
2. When was your last medical checkup?_____
3. Have there been any changes in your general health in the past year? ☐ YES ☐ NO
   If yes, explain:_____
4. Are you taking any medications or non-prescription drugs? ☐ YES ☐ NO
   If yes, please list:_____
5. Do you have any allergies? ☐ YES ☐ NO
   If yes, please list using the categories below:
   a) Medications
   b) Latex / rubber products
   c) Other eg. Hay fever, foods
6. Have you ever had a peculiar or adverse reaction to any medications or injections? ☐ YES ☐ NO
   If yes, explain:_____
7. Do you have or have you ever had asthma? ☐ YES ☐ NO
8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO
9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ☐ YES ☐ NO
10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO
11. Have you ever been advised by your doctor to take antibiotics before your dental treatment? ☐ YES ☐ NO
12. Do you have any conditions or therapies that could affect your immune system? ☐ YES ☐ NO
    Eg. Leukemia, AIDS, HIV, radiotherapy, chemotherapy.
13. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO
14. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO
15. Have you ever been hospitalized for any illnesses or operations? ☐ YES ☐ NO
    If yes, explain:_____
16. Do you have or have you had any of the following? Please check all that apply. ☐ YES ☐ NO

☐ chest pain ☐ shortness of breath ☐ pacemaker ☐ steroid therapy ☐ seizures
☐ drug/alcohol dependancy ☐ heart attack ☐ lung disease ☐ diabetes
☐ kidney disease ☐ stroke ☐ prosthetic heart valve ☐ tuberculosis ☐ cancer ☐ arthritis

17. Are there any diseases or medical problems that run in your family? Eg. Diabetes, cancer_____ ☐ YES ☐ NO

18. Do you smoke or chew tobacco? If so, how much?_____ ☐ YES ☐ NO

19. For women only. Are you breast feeding or pregnant? If pregnant, what is the expected delivery date?_____ ☐ YES ☐ NO

DENTAL

What is your main reason for your visit to our office?_____
_____

Date of your last dental visit?_____ Last dental cleaning?_____Last x-ray?_____

Are you nervous during dental treatment? ☐ YES ☐ NO
Are you unhappy with the appearance or colour of your teeth? What would you like to see changed? ☐ YES ☐ NO
_____
_____

Have you ever had Orthodontic treatment? (Braces) ☐ YES ☐ NO
Have you ever had your wisdom teeth removed? ☐ YES ☐ NO
Have you ever had any Periodontal (Gum) surgery? ☐ YES ☐ NO

At what interval were you previously seeing your hygienist?

3 months 4 months 6 months 9 months

If you wear dentures, approximately how old are they? _____Years.

Do you presently have any pain? ☐ YES ☐ NO
If so, how long have you had it?_____Days.
If so, where is it? Upper Right Upper Left
Lower Right Lower Left

Do you have any specific concerns that you would like to talk about? ☐ YES ☐ NO
_____
_____

To the best of my knowledge, the above information is correct and should there be any change in my health status in the future, I will advise this dental office.

Patient/Parent/Guardian Signature:_____Date:_____

Reviewed by Treating Dentist:_____

Name:_____ D.O.B: M____D____Y_____

Medical Alert/Condition?Allergies:_____

Date:	Changes	PT Signature:	Reviewed By: