MEDICAL HISTORY QUESTIONNAIRE

NAME:

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

ADDRESS (HOME):

PHONE:

EMAIL ADDRESS:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE :

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care.
All the information is strictly private, and protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand.

1. Are you being treated for any medical condition presently or have you been treated within the past year? If so, why?

☐ 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.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

a) Medications
b) Latex/ rubber products
c) Other (e.g hayfever, foods)

☐ YES ☐ NO ☐ NOT SURE/MAYBE

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, or 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

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

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therap	☐ seizures (epilepsy)	☐ osteoporosis medications (e.g. Fosamax, Actonel)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke		☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
☐ shortness of breath	☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alchool dependecy	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family?

☐ 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

For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

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

PATIENT/ PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES:

DENTAL HISTORY QUESTIONNAIRE

- When was your last dental visit? _____
- When did you last have dental x-rays? _____
- How often do you brush your teeth? _____
- How often do you floss your teeth? _____
- Have you been seeing a dentist regularly? **Yes/ No**
- Do any of your teeth ache? **Yes/ No**
- Have you ever been advised to take antibiotics before dental appointments? **Yes/ No**
- Do your gums bleed when you brush? **Yes/ No**
- Do you have pain when you chew? **Yes/ No**
- Do you feel that you have bad breath? **Yes/ No**
- Have you ever been in a car accident or experienced any blows to your jaw? **Yes/ No**
- Have you ever had any implant surgery in one or both of your jaws or jaw joints? **Yes/ No**

  If you answered " **yes** ", to the last question, who did the surgery and when was it done?

  _____

  _____

- Are you being followed up by a dental specialist **Yes/ No**
- Please list anything else not mentioned above regarding your past dental history.

  _____

  _____