TODAY'S DATE:_____

Medical History Questionnaire

Welcome to our office. 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. Please ask if you wish to review our Privacy Policy. The dentist will review the information and our staff will help you complete the form if necessary. Please complete both sides of the questionnaire.

Your Name: Ms/Mrs./Miss/Mr./Dr./Rev.

_____

Date of Birth _____

Box # _____Street #_____

Town_____Postal Code _____

Telephone: Home_____

Business _____

Occupation _____

Employer _____

Health Card #_____

Medical Doctor _____

Phone number _____

Specialist(s) _____

Spouse's Name _____

Spouse's Employer _____

In case of emergency, we should notify:

Name _____

Relationship _____

Daytime Telephone _____

Who referred you to our practice? _____

Do you have dental benefits? ☐ Group _____Policy Number_____

Please answer the following questions:

1. Are you being treated for ***any*** medical condition or have you been treated within the past year? _____If so, provide details

_____

2. When was your last medical checkup?_____

3. Has there been any change in your general health in the last year? _____ If yes, please explain

_____

4. Are you taking ***any*** medications, non-prescription drugs or supplements, or herbal remedies? _____If yes, please list

_____

5. Do you have ***any*** allergies or had a peculiar or adverse reaction to any medication or injection? _____ If yes, explain

_____

Are you allergic to ***Penicillin*** ☐ or ***Latex/rubber*** ☐?

6.Women only: Are you pregnant ☐ or breastfeeding? ☐ If pregnant, when are you due?

Please complete the other side

7. Do you have or have you ever had any of the following? Please circle ***any*** which apply to you.

Heart problems :angina heart attack heart murmur mitral valve prolapse rheumatic fever prosthetic heart valve pacemaker cardiac bypass other ____

Bloodpressure: High Low Stroke Bleeding problems ____ Blood disorders other

Lung disease: Asthma Shortness of breath tuberculosis emphysema other

Cancer Steroid Therapy Radiation Therapy Chemotherapy Arthritis Diabetes

Stomach ulcers other Gastro-intestinal disease Kidney disease Thyroid disease

Hepatitis or jaundice other Liver disease AIDS/HIV Joint replacement ____

Seizures or Epilepsy other Neurological disease or disorder Mental illness

Drug/Alcohol Dependancy

8. Are there any other conditions or diseases that you have or have had? ____ If yes, please provide details

_____

9. Have you ever been advised by your doctor to take an antibiotic before dental treatment? _____ If so, why? _____

10. Do you smoke or use tobacco products ? ____ If so, what type and how often? _____

11. When was your last dental visit? _____ Name of your last dentist _____

12. Are you aware of problems you may have or have had related to any of the following:

Gums Chewing Swelling Pain or sensitivity Tooth decay Jaw joints

Broken teeth Missing Teeth Bad breath Appearance Mouth Sores

13. Are you nervous about dental treatment? If so, what in particular? _____

14. Have you had specialist dental treatment such as gum treatment, implants, or orthodontics?

_____

15. Briefly describe the reason for your visit today. _____

_____

Patient Consent to Dental Treatment

I hereby consent to the rendering of dental treatment and oral surgical procedures deemed necessary and/or advisable for me. This includes radiographs (x-rays), local anaesthetic (freezing), and conscious sedation (nitrous oxide). I assume full responsibility for professional and laboratory fees and costs incurred and understand that these are due and payable at the time of service. *I understand that a fee will be charged for broken or failed appointments when at least 24 hours notice is not provided.*

Date: _____ Patient's Signature_____