MEDICAL HISTORY

Patient Legal Name _____ Preferred Name _____

Date of Birth _____ (Month/Day/Yr) Age _____ Care Card #_____

Name of Physician/and their specialty _____ Most recent physical examination _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
PLEASE CIRCLE THOSE WHICH APPLY TO YOU		
1. Hospitalization for illness or injury_____	☐	☐
2. An allergic reaction to:		
☐Aspirin, ibuprofen, acetaminophen, codeine		
☐Penicillin, Erythromycin (please circle)		
☐Sulpha, Tetracycline (please circle)		
☐Local anaesthetic		
☐Fluoride		
☐Metals (nickel, gold, silver, _____)		
☐Latex		
☐Other_____		
3. Heart problems, or cardiac stent?	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artificial prosthesis (heart valve or joints)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorders	☐	☐
12. Prolonged bleeding due to a slight cut (INR >3.5)	☐	☐
13. Emphysema, sarcoidosis	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (ie. Snoring, sinus)	☐	☐
17. Kidney disease, liver disease or jaundice (please circle)	☐	☐
18. Thyroid, parathyroid disease or calcium deficiency	☐	☐
19. Hormone deficiency	☐	☐
20. High cholesterol or taking statin drugs	☐	☐

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
PLEASE CIRCLE THOSE WHICH APPLY TO YOU		
21. Diabetes (HbA1c=_____)	☐	☐
22. Stomach or duodenal ulcer	☐	☐
23. Digestive disorders (ie. Gastric reflux)	☐	☐
24. Oesteoporosis/osteopenia (ie.Taking bisphosphonates)	☐	☐
25. Arthritis	☐	☐
26. Glaucoma	☐	☐
27. Contact lens	☐	☐
28. Head or neck injuries	☐	☐
29. Epilepsy, convulsions (seizures)	☐	☐
30. Neurologic problems (attention deficit disorder)	☐	☐
31. Viral infections and cold sores	☐	☐
32. Any lumps or swelling in the mouth	☐	☐
33. Hives, skin rash, hay fever	☐	☐
34. Veneral disease	☐	☐
35. Hepatitis (type ____); Human Papilloma Virus	☐	☐
36. HIV/AIDS	☐	☐
37. Chemotherapy, radiation therapy (please circle)	☐	☐
38. Alcohol/drug dependency	☐	☐
39. Human Papilloma Virus (HPV)	☐	☐
ARE YOU:	☐	☐
39. Presently being treated for any other illness	☐	☐
40. Subject to frequent headaches	☐	☐
41. A smoker, smoked previously, use snuff, chewing tobacco	☐	☐
42. FEMALE - taking birth control pills	☐	☐
43. FEMALE - pregnant (how many weeks ____)	☐	☐
-Nursing	☐	☐
44. MALE - with any prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possible affect your dental treatment: _____

_____

List all vitamins, medications, and or supplements.

Herb/Drug/Vitamin	Purpose	Herb/Drug/Vitamin	Purpose

If a medical emergency should arise, please indicate an emergency contact name and all phone contact information:

Emergency Contacts Name:_____ Relationship _____

Home phone:_____ Work phone: _____ Cellular phone: _____

PLEASE CONTINUE ON OTHER SIDE ⟶

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ (Mth/Day/Yr) Date of most recent x-rays ____/____/____ (Mth/Day/Yr)

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: ☐ 3 months ☐ 4 Months ☐ 6 months ☐ 9 Months ☐ 12 Months ☐ Not routinely

Do you have dental insurance: ☐ YES ☐ NO

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: (circle those that apply)	**YES**	**NO**
PERSONAL HISTORY		
1a. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [_____] _____	☐	☐
1b. Have you had an unfavourable dental experience?_____	☐	☐
2. Have you ever had trouble getting numb or had any reactions to local anaesthetic? _____	☐	☐
3. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
SMILE CHARACTERISTICS		
4. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
5. Have you ever whitened (bleached) your teeth? _____	☐	☐
6. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
7. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
8. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
9. Do you clench or grind your teeth during night time or daytime? _____	☐	☐
10. Do you wear or have you ever worn a bite appliance (ie. Night guard)? _____	☐	☐
TOOTH STRUCTURE		
11. Does your mouth feel "dry" (please circle one - often/occasionally/always) _____	☐	☐
12. Do you feel or notice any holes (ie. Pitting, craters) on the biting surface of your teeth? _____	☐	☐
13. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
GUM AND BONE		
14. Do your gums bleed when brushing or flossing? _____	☐	☐
15. Have you ever been treated for gum disease or been told you have bone lost around your teeth? _____	☐	☐

Patient's Signature_____ Date _____

Signature of guardian _____ Relationship to Patient _____