

MEDICAL HISTORY QUESTIONNAIRE

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? Yes No Not sure/Maybe

2. When was your last medical checkup? Yes No Not sure/Maybe

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. Yes No Not sure/Maybe
 a) Medications b) Latex/Rubber products c) Other e.g. hayfever, foods...

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 heart murmur, mitral valve prolapse or rheumatic fever? Yes No Not sure/Maybe

10. Do you have a prosthetic or artificial joint? Yes No Not sure/Maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes No Not sure/Maybe

12. Do you have any conditions or therapies that could affect your immune system e.g. Leukemia, AIDS, HIV Infection, Radiotherapy, Chemotherapy? Yes No Not sure/Maybe

13. Have you ever had hepatitis, jaundice, or liver disease? Yes No Not sure/Maybe

14. Do you have a bleeding problem or bleeding disorder? Yes No Not sure/Maybe

15. Have you ever been hospitalized for any illness or operations? If yes, please explain. Yes No Not sure/Maybe

16. Do you have or have you ever had any of the following? If yes, please explain. (Please circle)

Chest Pain, Angina	Shortness of breath	Pacemaker	Steroid therapy	Seizures (Epilepsy)
Drug/Alcohol Dependency	Heart Attack	Lung Disease	Diabetes	Kidney Disease
Stroke	Prosthetic Heart Valve	Tuberculosis	Stomach Ulcers	Thyroid Disease
Cancer	Arthritis	Diet Pill Therapy		
17. Are there any conditions or diseases not listed above that you have or have had? If so, what? Yes No Not sure/Maybe

18. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes No Not sure/Maybe

19. Do you smoke or chew tobacco products? Yes No Not sure/Maybe

20. Are you nervous during dental treatment? Yes No Not sure/Maybe

21. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not sure/Maybe

DENTAL HISTORY QUESTIONNAIRE

Please check YES or NO to each question. If you are unsure of a question, please consult with the dentist.

Is there a dental problem you would like treated immediately? Yes No

Date of last dental visit: _____ Date of last dental cleaning: _____

Date of last dental x-rays: _____

1. Have you been seeing a dentist regularly? Yes No
2. Have you ever had any of the following? Yes No
 - Periodontal treatment? (treatment of gums) Yes No
 - Orthodontic treatment? (to straighten or realign teeth) Yes No
 - A bite plate or any other appliance? Yes No
 - Your bite adjusted or teeth ground? Yes No
 - Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints? Yes No
If yes, who performed the surgery? _____ When? _____
 - Are you being followed up by a dental specialist? Yes No
3. Are there any growths or sore spots in your mouth? Yes No
4. Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? Yes No
5. Have you noticed any loose teeth, or have any of your teeth shifted? Yes No
6. Does food catch between your teeth? Yes No
7. Are any of your teeth sensitive to heat, cold, sweets, or pressure? Yes No
8. Have you been advised to take antibiotics before a dental appointment? Yes No
9. Do you use dental floss, proxabrush, or stimulents? How often? _____ Yes No
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? Yes No
11. Have you ever experience any of the following jaw problems? Yes No
 - Popping/clicking in your jaws? Yes No
 - Pain in your jaw joints, around your ear, or side of your face? Yes No
 - Difficulty in opening or closing? Yes No
 - Pain when teeth are clenched? Yes No
 - Pain or difficulty while chewing? Yes No
12. Do you have any of the following habits? Yes No
 - Clenching or grinding your teeth while awake or asleep? Yes No
 - Biting your cheeks or lips? Yes No
 - Mouth breathing while awake or asleep? Yes No
 - Placing foreign objects in your mouth? (e.g. pencils, nails, pins, fingernails) Yes No
13. Do you have any emotional concerns about having dental treatment? Yes No
14. Are you unhappy with the appearance of your teeth? Yes No
What would you like to see changed? _____
15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns? Yes No

OFFICE POLICIES

A service charge of 4% per month may be charged to accounts exceeding 30 days. There will may be a monetary charge for appointments cancelled without at least 48 hours advance notice from the time of the scheduled appointment. We cannot guarantee appointments for patients who arrive more then 15 minutes late of their scheduled appointment.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowing omitted any information. I give my permission to telephone or email me to discuss matters related to this form. I have had the opportunity to ask questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____

(Signature) Patient Parent Gaurdian

(Print Name of Guardian)

RECALL HISTORY

NAME: MR/MISS/MRS/MS/DR _____

Please review your medical history (dated ____/____/____) and advise your dentist if there are any changes.

1. Has there been any changes in your health, such as serious illness, hospitalizations or new allergies? If yes, please specify. Yes No Not sure/Maybe
2. Are you taking any new medication or has there been any change in your medications? If yes, please specify. Yes No Not sure/Maybe
3. Have you had a heart murmur diagnosed or had any change in an existing cardiac problem or murmur? Yes No Not sure/Maybe
4. When was your last medical checkup? _____
5. Were any problems identified? If yes, please explain. Yes No Not sure/Maybe
6. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not sure/Maybe

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

PATIENT/PARENT/GAURDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____

NAME: MR/MISS/MRS/MS/DR _____

Please review your medical history (dated ____/____/____) and advise your dentist if there are any changes.

1. Has there been any changes in your health, such as serious illness, hospitalizations or new allergies? If yes, please specify. Yes No Not sure/Maybe
2. Are you taking any new medication or has there been any change in your medications? If yes, please specify. Yes No Not sure/Maybe
3. Have you had a heart murmur diagnosed or had any change in an existing cardiac problem or murmur? Yes No Not sure/Maybe
4. When was your last medical checkup? _____
5. Were any problems identified? If yes, please explain. Yes No Not sure/Maybe
6. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not sure/Maybe

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

PATIENT/PARENT/GAURDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____

NAME: MR/MISS/MRS/MS/DR _____

Please review your medical history (dated ____/____/____) and advise your dentist if there are any changes.

1. Has there been any changes in your health, such as serious illness, hospitalizations or new allergies? If yes, please specify. Yes No Not sure/Maybe
2. Are you taking any new medication or has there been any change in your medications? If yes, please specify. Yes No Not sure/Maybe
3. Have you had a heart murmur diagnosed or had any change in an existing cardiac problem or murmur? Yes No Not sure/Maybe
4. When was your last medical checkup? _____
5. Were any problems identified? If yes, please explain. Yes No Not sure/Maybe
6. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not sure/Maybe

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

PATIENT/PARENT/GAURDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____