45 Grist Mill Rd. Unit 6B
Holland Landing, Ontario, L9N 1M7
Tel: (905) 235-7800

MEDICAL & DENTAL HEALTH HISTORY

PATIENT INFORMATION

FULL NAME: _____ SEX: M☐ / F☐ HEIGHT: _____ WEIGHT: _____

DATE OF BIRTH (MM/DD/YYYY): ____/____/____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PHYSICIANS NAME: _____ ADDRESS: _____ PHONE: _____

MAY WE CONTACT YOU AT WORK? Y☐ / N☐ WHOM MAY WE THANK FOR REFERRING YOU? _____

EMAIL: _____ DO YOU PREFER TO BE CONTACTED BY EMAIL Y☐ / N☐

PERSON RESPONSIBLE FOR ACCOUNT

MYSELF ☐ / OTHER☐ (NAME/RELATIONSHIP): _____

EMERGENCY CONTACT (NAME/RELATIONSHIP): _____

HOME PHONE: _____ CELL PHONE: _____

Please answer all questions truthfully and to the best of your ability as it may effect treatment outcomes, or put you at MEDICAL RISK. All information is strictly private and is treated with complete confidentiality. All questions will be reviewed with you, and anything you do not understand will be fully explained.

HEALTH HISTORY

		YES	NO
1.	Has there been any change in your general health the past year?	☐	☐
	If YES *please describe*: _____		
2.	Are you now being treated for any medical condition, or have you been treated within the past two years?.....	☐	☐
	If YES *please describe*: _____		
3.	Are you under the care of a specialist, or physician?.....	☐	☐
	If YES *please describe*: _____		
4.	When was your last medical visit?_____		
5.	Have you ever had serious illness, operation, or been hospitalized?.....	☐	☐
6.	Do you have any allergies?(If YES please list: Medications, Latex/rubber products, metals, foods, other).....	☐	☐
	_____		
7.	Do you use any tobacco products?.....	☐	☐
	If YES *please list type/amount/frequency/# of years*:_____		

YES NO

8. Please list any current medications, non prescription drugs, or herbal supplements of any kind?..... ☐ ☐

If YES please provide the following information:

Condition	Drug	Dosage	Frequency

9. Do you have, or have had any of the following diseases or problems:

a. **Cardiovascular disease:** *(Check all that apply)*

☐ Heart Trouble ☐ Heart Attack ☐ Bypass Surgery
☐ High or Low Blood Pressure ☐ Heart Surgery ☐ Damaged Heart Valve
☐ Heart Murmur ☐ Irregular Heartbeat/arrhythmia ☐ Coronary Angioplasty/Stent
☐ Mitral Valve Prolapse ☐ Stroke ☐ Arteriosclerosis
☐ Congenital Heart Defect/Lesion ☐ Congestive Heart Failure/disease ☐ Rheumatic Fever/Scarlet Fever
☐ Artificial Heart Valve ☐ Angina/chest pains ☐ Other:

If Other *please describe*: _____

YES NO

b. Cardiac Pacemaker..... ☐ ☐

c. Respiratory conditions..... ☐ ☐

(i.e. Asthma, Tuberculosis, emphysema, persistent cough, sinus trouble, lung disease, COPD)

If YES *please describe*: _____

d. Abnormal bleeding associated with previous extractions, surgery, trauma..... ☐ ☐

e. Blood disorder such as anemia, hemophilia, or leukemia..... ☐ ☐

f. Fainting or dizzy spells..... ☐ ☐

g. Epilepsy, seizures or convulsions..... ☐ ☐

h. Diabetes ..... ☐ ☐

If YES *please check:* Type 1☐ Type 2☐ ALSO Controlled ☐ or Uncontrolled ☐

i. Liver disease; Jaundice; or Hepatitis *If yes to Hepatitis, indicate type:*_____ ☐ ☐

j. Kidney or bladder trouble (including dialysis)..... ☐ ☐

k. Thyroid disorder (Hypothyroid, Goiter, Thyroid removed) ..... ☐ ☐

l. Organ transplant ..... ☐ ☐

m. Osteoporosis ..... ☐ ☐

n. Arthritis or inflammatory rheumatism (painful swollen joints) ..... ☐ ☐

o. Joint replacement (i.e. hip/knee)..... ☐ ☐

If YES*, which joint, and when?*_____

p. Cancer *if YES, where, and when diagnosed?*..... ☐ ☐

r. Psychiatric Conditions (including depression and anxiety)..... ☐ ☐

q. Immunodeficiency disorder (i.e. HIV/AIDS, lupus, sickle cell anemia)..... ☐ ☐

r. Have you ever had a blood transfusion? *If YES, when?*_____ ☐ ☐

s. Alcohol dependency..... ☐ ☐

t. Recreational drug use (i.e. Marijuana, Cocaine)..... ☐ ☐
If YES*, please list what drugs you take?*_____

YES NO

u. Trauma or injury to head or neck *If YES, when, and where?*_____ ☐ ☐
v. Stomach problems, including ulcers, nausea, acid reflux, etc..... ☐ ☐
w. Have you ever had surgery, radiation, or chemotherapy to treat a tumor, or cancer, or other condition?..... ☐ ☐

10. Have you had any X-Rays (dental and/medical) taken in the last 5 years? ..... ☐ ☐
If YES*, when, and how many?*_____
11. Do you, or have you had any other condition not mentioned above? ..... ☐ ☐
If YES*, please specify?*_____

FEMALE CLIENTS ONLY

12. Are you pregnant or suspect you may be pregnant? *If* YES*, when is the due date?*_____ ☐ ☐
13. Are you currently nursing? ..... ☐ ☐
14. Are you taking birth control pills? ..... ☐ ☐
15. Are you taking a hormone replacement? ..... ☐ ☐

DENTAL HISTORY

16. Do you breathe through your mouth while asleep or awake?..... ☐ ☐
17. Do you bite your cheeks, lips, fingernails, or pens regularly? ..... ☐ ☐
18. Are you nervous about receiving dental care? ..... ☐ ☐
19. Have you ever experienced serious trouble associated with previous dental care? ..... ☐ ☐
20. Have you ever been advised to take antibiotics before dental treatment? ..... ☐ ☐
21. Have you had prolonged bleeding following extractions in the past? ..... ☐ ☐
22. Are there any growths or sore spots in your mouth? ..... ☐ ☐
23. Have you ever been diagnosed with periodontal disease? ..... ☐ ☐
24. Do you ever have a dry or burning mouth? ..... ☐ ☐
25. When was your last dental care visit? _____
26. Do you find yourself clenching or grinding you teeth? ..... ☐ ☐
27. Do you have any jaw soreness, or difficulty opening your mouth? ..... ☐ ☐
28. Do you have any other concerns not previously mentioned? ..... ☐ ☐
29. Do you have any Dental Problems? *(i.e. sore teeth/gums, sensitivity to hot/cold/sweet, bleeding gums)* ..... ☐ ☐
If YES*, please describe?*_____

I verify that I understand all the questions asked in the health questionnaire. I also verify that the information given is correct. I authorize the dentist and/or dental hygienist to discuss any medical questions related to my dental treatments with my physician. I authorize the Dentist to release any information to the Insurance Company if necessary to secure my dental treatment. I understand that I am financially responsible for all charges whether or not paid by my Insurance.

Patient/Guardian Signature: _____ **Date:** _____