

MEDICAL HISTORY

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LAST NAME

FIRST NAME

DATE OF BIRTH

IN CASE OF EMERGENCY,
CONTACT NAME

PHONE

1. ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION AT THE PRESENT OR HAVE BEEN TREATED WITHIN THE PAST YEAR?

2. WHEN WAS YOUR LAST MEDICAL CHECKUP?

3. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?

4. ARE YOU TAKING ANY MEDICATIONS, NON-PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS OF ANY KIND?

IF YES, PLEASE LIST (INCL. NAMES & DOSAGES).

5. DO YOU HAVE ANY ALLERGIES?

IF YES, PLEASE LIST USING THE CATEGORIES: a) MEDICATION b) LATEX/RUBBER PRODUCTS c) OTHER e.g. HAYFEVER, FOODS

6. HAVE YOU EVER HAD A PECULIAR OR ADVERSE REACTION TO ANY MEDICINES OR INJECTION?

IF YES, PLEASE EXPLAIN.

7. DO YOU HAVE OR HAVE YOU EVER HAD ASTHMA?

8. DO YOU HAVE OR HAVE YOU EVER HAD ANY HEART OR BLOOD PRESSURE PROBLEMS?

9. DO YOU HAVE OR HAVE YOU EVER HAD A HEART MURMUR, MITRAL VALVE PROLAPSE OR RHEMATIC FEVER?

10. DO YOU HAVE A PROSTHETIC OR ARTIFICIAL JOINT?

11. HAVE YOU EVER BEEN ADVISED BY YOUR DOCTOR/DENTIST TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?

12. DO YOU HAVE ANY CONDITIONS OR THERAPIES THAT COULD EFFECT YOUR IMMUNE SYSTEM e.g. LEUKEMIA, AIDS, HIV INFECTION, RADIOTHERAPY, AND CHEMOTHERAPY?

13. HAVE YOU EVER HAD HEPATITIS, JAUNDICE OR LIVER DISEASE?

14. DO YOU HAVE A BLEEDING PROBLEM OR BLEEDING DISORDER?

15. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR OPERATIONS?

IF YES, PLEASE EXPLAIN.

16. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK.

- CHEST PAIN, ANGINA
- SHORTNESS OF BREATH
- CANCER
- STEROID THERAPY
- SEIZURES (EPILEPSY)
- HEART ATTACK
- PROSTHETIC HEART VALVE

- LUNG DISEASE
- DIABETES
- KIDNEY DISEASE
- STROKE
- PACEMAKER
- TUBERCULOSIS
- STOMACH ULCERS
- THYROID DISEASE
- DRUG OR ALCOHOL DEPENDENCY
- ARTHRITIS
- DIET PILL THERAPY
- NONE OF THESE

17. ARE THERE ANY CONDITIONS OR DISEASES NOT LISTED ABOVE THAT YOU HAVE OR HAVE HAD? IF YES, PLEASE LIST.

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18. ARE THERE ANY DISEASES OR MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY? (e.g. DIABETES, CANCER OR HEART DISEASE)

IF YES, PLEASE LIST.

19. DO YOU SMOKE OR CHEW TOBACCO PRODUCTS?

20. DO YOU USE CANNABIS/MARIJUANA? IF SO, HOW FREQUENTLY?

21. ARE YOU NERVOUS DURING DENTAL TREATMENT?

22. FOR WOMEN ONLY: ARE YOU BREAST-FEEDING OR PREGNANT?

BLOOD PRESSURE READING (OFFICE USE)

DENTAL HISTORY

1. WHEN WAS YOUR LAST DENTAL VISIT?

2. WHEN DID YOU LAST HAVE DENTAL X-RAYS?

3. HOW OFTEN DO YOU BRUSH YOUR TEETH?

4. HOW OFTEN DO YOU FLOSS YOUR TEETH?

**5. HAVE YOU BEEN SEEING A DENTIST
REGULARLY?**

6. DO ANY OF YOUR TEETH ACHE?

7. DO YOUR GUMS BLEED WHEN YOU BRUSH?

8. DO YOU HAVE ANY PAIN WHEN YOU CHEW?

9. DO YOU FEEL THAT YOU HAVE BAD BREATH?

**10. ARE THERE ANY GROWTH'S OR SORE SPOTS
IN YOUR MOUTH?**

11. HAVE YOU EVER BEEN IN A VEHICLE ACCIDENT OR EXPERIENCED ANY BLOWS TO YOUR JAW?

12. HAVE YOU EVER HAD ANY IMPLANT SURGERY IN ONE OR BOTH OF YOUR JAWS OR JAW JOINTS?

13. ARE YOU BEING FOLLOWED-UP BY DENTAL SPECIALISTS?

14. PLEASE LIST ANYTHING ELSE NOT MENTIONED ABOVE REGARDING YOUR PAST DENTAL HISTORY.

15. WHAT DO YOU LOOK FOR MOST IN A DENTIST/DENTAL OFFICE?

GENERAL RELEASE

I AGREE

- I, the undersigned, certify that I have provided an accurate and complete personal and medical-

dental history and have not knowingly omitted any information.

I AGREE

- I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary.

I AGREE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for my dental care.

I AGREE

- I understand that responsibility for payment for the dental services for myself or my dependents is mine, and I will assume responsibility for fees associated with these services.

I AGREE

- Should there be any changes in either my health or personal information, I will advise the dentist and patient coordinator.

Signature (to be signed at office)

Signed Date