PATIENT MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT *(office use only):*

DATE: ____/____/____
Day Month Year

Name: ☐ Mr. ☐ Miss. ☐ Mrs. ☐ Ms. ☐ Dr. _____
First Name Last Name

Date of Birth (Day/Month/Year): ____/____/____ Occupation: _____

Address (Home): _____ Home: ( ) _____
Street Apt#

_____ Cell: ( ) _____
City Postal Code

Email: _____ Bus Phone: ( ) _____

Who referred you to our office? _____

Employer _____ Insurance Company _____

Group / Policy NO._____ Certificate / ID NO. _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____ Relationship: _____ Day Time Phone: ( ) _____

Name of Family Doctor: _____ Phone: _____

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.

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? _____

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? _____ ☐ Yes ☐ No ☐ Not Sure/Maybe

4. Do you have any allergies? If you answered yes, please list: ☐ Yes ☐ No ☐ Not Sure/Maybe

   a) medications _____ b) latex products _____ c) hay fever, foods _____

5. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain. _____ ☐ Yes ☐ No ☐ Not Sure/Maybe

6. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

7. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe

8. Do you any conditions or therapies that could affect your immune system, e.g. leukaemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No ☐ Not Sure/Maybe

9. Have you ever had hepatitis A, B, C, jaundice, liver disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

10. Do you have a bleeding problem, bleeding disorder or bruise easily? ☐ Yes ☐ No ☐ Not Sure/Maybe

11. Have ever been hospitalized for any illnesses or operations? ☐ Yes ☐ No ☐ Not Sure/Maybe

If yes, please explain. _____

12. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ pacemaker	☐ steroid therapy	☐ drug/alcohol dependency
☐ seizures (epilepsy)	☐ osteoporosis	☐ heart attack	☐ high/low blood pressure
☐ lung disease	☐ diabetes	☐ kidney disease	☐ thyroid disease
☐ stroke	☐ tuberculosis	☐ stomach ulcers	☐ shortness of breath
☐ cancer	☐ arthritis	☐ medications (e.g. Fosamax, Actonel)	

13. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ Yes ☐ No ☐ Not Sure/Maybe _____

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

15. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe

16. For women only: Are you breastfeeding or pregnant?

If pregnant, what is the expected delivery date? _____

DENTAL HISTORY QUESTIONTIONNAIRE

Have you been seeing a dentist reguarly?	☐ Yes ☐ No ☐ Not Sure/Maybe
Do any of your teeth ache?	☐ Yes ☐ No ☐ Not Sure/Maybe
Have you ever been advised to take antibiotics before dental appointments?	☐ Yes ☐ No ☐ Not Sure/Maybe
Do your gums bleed when you brush?	☐ Yes ☐ No ☐ Not Sure/Maybe
Do you have any pain when you chew?	☐ Yes ☐ No ☐ Not Sure/Maybe
Do you feel that you have bad breath?	☐ Yes ☐ No ☐ Not Sure/Maybe
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐ Yes ☐ No ☐ Not Sure/Maybe

Are you being followed up by a dental specialist? _____

Please list anything else not mentioned above regarding your past dental history.

_____

OFFICE POLICY

On behalf of our patients, we will assist with the insurance claim forms and clarify the insurance coverage the best we can. As all plans are different, services covered by dental insurance companies may vary. It is the patient's responsibility to understand his/her own dental insurance coverage.
Once you have made an appointment, please remember that this time has been reserved for you.
Please note that we require a minimum 48 hours notice if you need to cancel or reschedule your appointment.
A fee may be charged for cancelled or missed appointments without the 48 hours notice.

I have read and fully understand the office policy. I have provided accurate personal and medical dental history.
I understand that I am responsible for all dental fees for myself and my dependents regardless of the amount of dental insurance coverage.

x _____ _____

(Signature) Patient Parent Guardian (Print name of guardian)