

# MEDICAL HISTORY QUESTIONNAIRE

## \*MEDICAL ALERT:

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

DATE OF BIRTH (DAY/MONTH/YEAR):    /    /

ADDRESS (HOME):

PHONE:

EMAIL:

## IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

OCCUPATION

## WHO REFERRED YOU TO OUR OFFICE?

Name of company:

Name of insured member:

Date of birth of insured member:

## Insurance information

Contract/Policy number:

ID/Certificate number:

**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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

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. 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

Intitals: \_\_\_\_\_

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 replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?  YES  NO  NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint?  YES  NO  NOT SURE/MAYBE

11. 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

12. Have you ever had hepatitis, jaundice or liver disease? Indicate which ne  YES  NO  NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder?  YES  NO  NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  YES  NO  NOT SURE/MAYBE

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

- |  |  |                                       |  |  |   |
|--|--|---------------------------------------|--|--|---|
| <input type="checkbox"/> chest pain, angina  | <input type="checkbox"/> rheumatic fever       | <input type="checkbox"/> pacemaker    | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy)     | <input type="checkbox"/> osteoporosis medications |
| <input type="checkbox"/> heart attack        | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes        | <input type="checkbox"/> kidney disease          | (e.g. Fosamax, Actonel)                           |
| <input type="checkbox"/> stroke              | <input type="checkbox"/> heart murmur          | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers  | <input type="checkbox"/> thyroid disease         |   |
| <input type="checkbox"/> shortness of breath |  | <input type="checkbox"/> cancer       | <input type="checkbox"/> arthritis       | <input type="checkbox"/> drug/alcohol dependency |   |

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?  Yes  NO  NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)  YES  NO  NOT SURE/MAYBE

18. Do you smoke or chew tobacco products?  YES  NO  NOT SURE/MAYBE

19. Are you nervous during dental treatment?  YES  NO  NOT SURE/MAYBE

20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?  YES  NO  NOT SURE/MAYBE

**To the best of my knowledge, the above information is correct:**

PATIENT/PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

DENTIST SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

I agree to have emails and text messages sent to me by Dundas and Main Dentistry.

Signature: \_\_\_\_\_