PATIENT MEDICAL DENTAL HISTORY

DENTIST: _____

PATIENT INFORMATION

Name _____ Date of Birth _____
Address _____ Postal Code _____
Occupation _____ Home Phone _____ Bus. Phone _____
Next of Kin _____ Relationship _____ Bus. Phone _____
Dentist _____ Town _____ How long _____
Medical Physician _____ Medical Specialist _____
Reason for visit _____

The following information is necessary for this office to provide dental care in a manner that is compatible with your general health. Although some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health. **Please fill out both sides of this sheet and sign.**

NOTES

MEDICAL HISTORY (Please circle Yes or No)

1. Are you in good health? Y N
2. Have you been under the care of a physician during the last 2 years? Y N
   Condition being treated _____
3. Date of last physical examination _____
4. Have you had any serious illness or operation? Y N
   If yes, what _____
5. Have you been hospitalized within the last 5 years? Y N

6. Circle any of the following which you have had or have at present:

Heart attack	Chest Pain	Arthritis	Drug Addiction
Heart disease or Failure	Shortness of Breath	Rheumatism	Venereal Disease
Heart Murmur	Swelling Ankles	Glaucoma	Cold Sores
Congenital Heart Lesions	Kidney Trouble	Epilepsy	Genital Herpes
Angina Pectoris	Stomach Ulcers	Fainting	Nervousness
Rheumatic Fever	Tuberculosis (TB)	Bruise Easily	Depression
Rheumatic Heart Disease	Emphysema	Malignant Hyperthermia	Psychiatric Tx.
Artificial Heart Valve	Allergies or Hives	AIDS (HIV pos)	Sickle Cell Disease
Heart Pacemaker	Asthma	Liver Disease	X-ray Treatment
Heart Surgery	Hay Fever	Hepatitis	Radiation
Artificial Joint/Prosthetics	Sinus Trouble	Yellow Jaundice	Chemotherapy
High Blood Pressure	Diabetes	Blood Transfusion	Anemia
Low Blood Pressure	Thyroid Disease	Haemophilia	Other
Stroke			

7. Have you had abnormal bruising or bleeding with extractions, surgery, or trauma? _____ Y N
8. Are you allergic or have you reacted adversely to:
   a) Local anaesthetics, Freezing (Novocain, Lidocaine), Other _____ Y N
   b) Penicillin or other antibiotics (Sulfa drugs etc) _____ Y N
   c) Barbiturates, sedatives, or sleeping pills _____ Y N
   d) Aspirin or Tylenol (ASA or Acetaminophen) _____ Y N
   e) Codeine or other narcotics _____ Y N
   f) Latex/Rubber _____ Y N
   g) Other _____ Y N
9. Are you taking any drug or medicine _____ Y N
   (Including non-prescription drugs, herbal supplements) _____
10. Do you smoke? Y N How many? _____
    Do you drink alcoholic beverages? Y N How many a week? _____
    Do you use illicit drugs? Y N
11. Have you had in the past or do you presently have any disease, condition, or problem not listed above?
    _____ Y N
12. FEMALE PATIENT: Are you pregnant? Month? _____ Y N
    Do you take oral contraceptives (birth control)? Y N

DENTAL HISTORY

NOTES

1. Are you having any discomfort at this time?_____ Y N
2. How frequently do you have to see your dentist? In the past. _____
3. Date of last dental visit? _____What was done?_____
4. How often do you brush your teeth? _____Floss? _____
5. Are you aware of any lump, swelling, ulcer, or sores in your mouth? _____ Y N
6. Do you grind your teeth? _____ Y N
7. Have you ever been given local anaesthetic (freezing)? _____ Y N
8. Any complications with #7? _____ Y N
9. Have you had any serious trouble with any previous dental treatment? Y N

   Please specify _____
10. Are you satisfied with the appearance of your teeth? _____ Y N
11. Would you like to keep your natural teeth? _____ Y N
12. Are you tense during dental visits? _____ Y N
13. Have your teeth shifted, have spaces opened between your teeth,

    or are your teeth flaring? _____ Y N
14. Do you currently experience? (**Circle** any that apply)

Loose teeth	Bad breath	Sensitive Teeth
Headache/Earache/Neck pain	Problems flossing	Bleeding gums
Food wedging between teeth	Sore gums	Clicking in jaw joint (TMJ)
Unsatisfactory dentures		

15. Have you had (**Circle** any that apply)

Orthodontics/Braces	TMJ or Bite Problems	Partial Dentures
Periodontics/Gum Treatment	Crowns or Bridges/Veneers	Implants
Endodontics/Root Canal	Restorations/Fillings	Bleaching
Bite Plan/Night Guard		

Comments (specify) _____

16. Describe what you would like done with your teeth. _____

_____

PATIENT (PARENT) CONSENT:

THIS IS TO CERTIFY THAT I, UNDERSIGNED CONSENT TO THE PERFORMING OF DENTAL WORK AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, INCLUDED IS THE USE OF LOCAL OR GENERAL ANAESTHETIC OR SEDATION INDICATED INCLUDING X-RAYS AND I WILL ASSUME THE RESPONSIBILITY FOR THE FEES ASSOCIATED WITH THOSE PROCEDURES.

I CONFIRM THAT I CAN READ AND UNDERSTAND ENGLISH OR FRENCH ON THE FORM ☐ YES ☐ NO IF NO, NAME/SIGNATURE OF THE STAFF PERSON WHO COMMUNICATED OR TRANSLATED THE INFORMATION. Signature _____

Parent's/Patient (if patient is under the age of 16) Consent for treatment

_____ _____

Signature Date

Dentist Signature:_____ Date _____

RENEWAL DATES:

_____ _____

Date Signature Date Signature

_____ _____

Date Signature Date Signature