

MEDICAL & DENTAL HISTORY QUESTIONNAIRE

Patient Information

Patient name (Mr./Miss/Ms./Mrs./Dr.)

Sex Male Female

Date of birth (day/month/year)

Address

Occupation

City

Postal code

Name of dentist

Home phone

Work phone

Who referred you to our office?

Cell

Other

Name of family doctor

Email

In case of emergency, we should notify

Relationship

Parent/Guardian Information (if applicable)

Mother's name

Father's name

Address if different from patient

Address if different from patient

City

Postal code

City

Postal code

Mother's work number

Cell

Father's work number

Cell

Who will be bringing the patient for the appointment?

Responsible party

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 doctor will review the questions and explain any that you do not understand. Please complete 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:

- A** Medications **B** Latex/rubber products
C Other (e.g. hayfever, foods) **D** Metal/nickel

- 6 Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

Yes No Not sure / maybe

- 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 an artificial 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

11 Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy?
 Yes No Not sure / maybe

12 Have you ever had hepatitis, jaundice or liver disease?
 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 illness 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="radio"/> Chest pain, angina | <input type="radio"/> Heart attack |
| <input type="radio"/> Stroke | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Rheumatic fever | <input type="radio"/> Mitral valve prolapse |
| <input type="radio"/> Heart murmur | <input type="radio"/> Pacemaker |
| <input type="radio"/> Lung disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cancer | <input type="radio"/> Steroid therapy |
| <input type="radio"/> Diabetes | <input type="radio"/> Stomach ulcers |
| <input type="radio"/> Arthritis | <input type="radio"/> Seizures (epilepsy) |
| <input type="radio"/> Kidney disease | <input type="radio"/> Thyroid disease |
| <input type="radio"/> Drug / alcohol dependency | <input type="radio"/> Osteoporosis medications
(e.g. Fosamax, Actonel) |

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

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

Dental Information

Date of last dental check up

Have you ever seen a Periodontist? Yes No

Name of Periodontist

Have you ever seen an Orthodontist before? Yes No

If yes, when?

Have you ever had orthodontic treatment? Yes No

If yes, when?

Are you seen every 6 months 9 months 12 months

Indicate any history of (check all that apply:)

- | | |
|--|---|
| <input type="radio"/> Tongue thrust | <input type="radio"/> Heart attack |
| <input type="radio"/> Mouth breathing | <input type="radio"/> Tonsil/adenoids removed |
| <input type="radio"/> Jaw joint problems | <input type="radio"/> Injury to face or teeth |
| <input type="radio"/> Speech/articulation problems | |

What concerns do you have about your teeth?

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

Patient / Parent / Guardian signature

Date

Orthodontist signature

Date