South Simcoe DENTAL CARE

Medical History Questionnaire

PRINT FULL NAME:

_____

DATE OF BIRTH (DD/MM/YY): _____

HOME PHONE NUMBER: _____

CELL PHONE NUMBER: _____

ADDRESS: _____

_____**Postal Code** _____

EMAIL ADDRESS: _____

OCCUPATION: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

NAME:_____

RELATIONSHIP:_____

PHONE NUMBER: _____

FAMILY DOCTOR: _____

PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US?

- ❑ **Shopping in Plaza**
- ❑ **Referred by Patient:** _____
- ❑ **Website/ Google Search**
- ❑ **Mail Advertisement**
- ❑ **Other**

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 & explain any that you do not understand. Please fill in the entire form.**
Please circle the best answer.

1. Are you currently being treated for any medical condition or have you been treated within the past year. **If yes, please explain.**

Yes **No** **Maybe**

_____

2. When was your last medical checkup? _____

3. Has there been any change in your general health this past year. Please explain.
Yes **No** **Maybe**

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements? If yes, please list them.
Yes **No** **Maybe**

_____

5. Do you have any allergies? **Yes** **No** **Maybe**

a) Medications _____

b) Latex/ Rubber Products _____

c) Other (e.g. Hay Fever, Seasonal/Environmental/Foods) _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
Yes **No** **Maybe**

_____

7. Do you or have you ever had Asthma? **Yes** **No** **Maybe**

8. Do you or have you ever had any blood pressure problems? **Yes** **No** **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 or a heart transplant?
Yes **No** **Not Sure/ Maybe**

10. Do you have a prosthetic or artificial joint? **Yes** **No** **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** **Maybe**

12. Have you ever had hepatitis, jaundice or liver disease? **Yes** **No** **Maybe**

13. Do you have a bleeding problem or a bleeding disorder? **Yes** **No** **Maybe**

14. Have you ever been hospitalized for any illnesses or operations? **Yes** **No** **Maybe**

15. Do you have any of the following? Please circle.

Chest Pain, angina	**rheumatic fever**	**pacemaker**	**steroid therapy**	**seizures (epilepsy)**
Heart attack	**mitral valve prolapsed**	**lung disease**	**diabetes**	**kidney disease**
Stroke, TIA	**tuberculosis**	**stomach ulcers**	**thyroid disease**	**shortness of breath**
Heart murmur	**cancer**	**arthritis**	**osteoporosis**	**drug/alcohol/ Cannabis dependency**

16. Is there any disease or medical problems not listed that you may have/had?? **Yes** **No** **Maybe**

_____

17. Are there any disease or medical problems that run in your family? (cancer, diabetes, ETC?) **Yes** **No**

_____

18. Do you smoke or chew tobacco products? **Yes** **No** **Maybe**

19. Are you nervous during dental treatment? **Yes** **No** **Maybe**

20. Are you breastfeeding or pregnant? If so, how far along? **Yes** **No** **Maybe**

21. Do you identify as a person with a disability? Please explain. **Yes** **No** **Maybe**

_____

22. When was your last dental visit?

_____

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

Patient/Parent/Guardian Signature: _____Date: _____

Dentist Signature: _____Date: _____