MEDICAL & DENTAL HISTORY QUESTIONNAIRE

PLEASE FILL BEFORE YOUR APPOINTMENT (Please Print)

PERSONAL INFORMATION

Last Name _____ First Name _____ Date of Birth (DD/MM/YY) _____

Preferred name (if different from First Name) _____ Age _____

Home Address _____ City _____ Province _____ Postal Code _____

(H) Phone _____ (W) Phone_____ (C) Phone _____

Email _____ Referred by _____

Place of Business _____ Occupation _____

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.

MEDICAL INFORMATION

Physician Name _____ Physician Specialty _____

General Health: ○ Excellent ○ Good ○ Fair ○ Poor

Most recent physical exam purpose _____

_____

DENTAL INFORMATION

How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist's Name _____ How long have you been a patient? _____ ○ Months or ○ Years

Date of most recent dental exam (DD/MM/YY) _____ Date of most recent x-rays (DD/MM/YY) _____

Date of most recent treatment (other than a cleaning) (DD/MM/YY) _____

I routinely see my dentist every: ○ 3 mo. ○ 4 mo. ○ 6 mo. ○ 12 mo. ○ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

_____

_____

_____

MEDICAL HISTORY

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____ ○ ○
2. an allergic or bad reaction to any of the following: _____ ○ ○
   - ☐ aspirin, ibuprofen, acetaminophen, codeine _____
   - ☐ penicillin _____
   - ☐ erythromycin _____
   - ☐ tetracycline _____
   - ☐ sulfa _____
   - ☐ local anesthetic _____
   - ☐ fluoride _____
   - ☐ chlorhexidine (CHX) _____
   - ☐ Iodine _____
   - ☐ metals (nickel, gold, silver, _____) _
   - ☐ latex _____
   - ☐ nuts _____
   - ☐ fruit _____
   - ☐ milk _____
   - ☐ red dye _____
   - ☐ other _____
3. heart problems, or cardiac stent within the last 6 months ○ ○
4. history of infective endocarditis _____ ○ ○
5. artificial heart valve, repaired heart defect (PFO) _____ ○ ○
6. pacemaker or implantable defibrillator _____ ○ ○
7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____ ○ ○
8. heart murmur, rheumatic or scarlet fever _____ ○ ○
9. high or low blood pressure _____ ○ ○
10. a stroke (taking blood thinners) _____ ○ ○
11. anemia or other blood disorder _____ ○ ○
12. prolonged bleeding due to a slight cut (or INR > 3.5) ____ ○ ○
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ ○ ○
14. chronic ear infections, tuberculosis, measles, or chicken pox _____ ○ ○
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____ ○ ○
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____ ○ ○
17. kidney disease _____ ○ ○
18. liver disease or jaundice _____ ○ ○
19. vertigo (e.g. "the room is spinning") _____ ○ ○
20. thyroid, parathyroid disease, or calcium deficiency _____ ○ ○
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____ ○ ○
22. high cholesterol or taking statin drugs _____ ○ ○
23. diabetes (HbA1c = _____) _____ ○ ○
24. stomach or duodenal ulcer _____ ○ ○
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____ ○ ○
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____ ○ ○
27. arthritis or gout _____ ○ ○
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____ ○ ○
29. glaucoma _____ ○ ○
30. contact lenses _____ ○ ○
31. head or neck injuries _____ ○ ○
32. epilepsy, convulsions (seizures) _____ ○ ○
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____ ○ ○
34. viral infections and cold sores _____ ○ ○
35. any lumps or swelling in the mouth _____ ○ ○
36. hives, skin rash, hay fever _____ ○ ○
37. STI/STD/HPV _____ ○ ○
38. hepatitis (type ____) _____ ○ ○
39. HIV/AIDS _____ ○ ○
40. tumor, abnormal growth _____ ○ ○
41. radiation therapy _____ ○ ○
42. chemotherapy, immunosuppressive medication _____ ○ ○
43. emotional difficulties _____ ○ ○
44. psychiatric treatment or antidepressant medication _____ ○ ○
45. concentration problems or ADD/ADHD _____ ○ ○
46. alcohol/recreational drug use _____ ○ ○

ARE YOU:

47. presently being treated for any other illness _____ ○ ○
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____ ○ ○
49. taking medication for weight management _____ ○ ○
50. taking dietary supplements, vitamins, and/or probiotics _____ ○ ○
51. often exhausted or fatigued _____ ○ ○
52. experiencing frequent headaches or chronic pain _____ ○ ○
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ ○ ○
54. considered a touchy/sensitive person _____ ○ ○
55. often unhappy or depressed _____ ○ ○
56. taking birth control pills _____ ○ ○
57. currently pregnant _____ ○ ○
58. diagnosed with a prostate disorder _____ ○ ○

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years:

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

DENTAL HISTORY

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	○	○
2. Have you had an unfavorable dental experience?	○	○
3. Have you ever had complications from past dental treatment?	○	○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	○	○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	○	○
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	○	○

GUM AND BONE

	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	○	○
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	○	○
9. Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
10. Is there anyone with a history of periodontal disease in your family?	○	○
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	○	○
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	○	○
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	○	○

TOOTH STRUCTURE

	YES	NO
14. Have you had any cavities within the past 3 years?	○	○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	○	○
18. Do you have grooves or notches on your teeth near the gum line?	○	○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	○	○
20. Do you frequently get food caught between any teeth?	○	○

BITE AND JAW JOINT

	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	○	○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	○	○
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	○	○
25. Are your teeth becoming more crooked, crowded, or overlapped?	○	○
26. Are your teeth developing spaces or becoming more loose?	○	○
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
30. Do you clench or grind your teeth together in the daytime or make them sore?	○	○
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	○	○
32. Do you wear or have you ever worn a bite appliance?	○	○

SMILE CHARACTERISTICS

	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	○	○
34. Have you ever bleached (whitened) your teeth?	○	○
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
36. Have you been disappointed with the appearance of previous dental work?	○	○

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made, payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume fully responsibility for the fees. I am aware that 2 business days of notice is required to change or cancel an appointment without charge.

X _____ _____

SIGNATURE, PARENT OR GUARDIAN IF UNDER 18 | DATE (DD/MM/YY)

_____ _____

DENTIST'S SIGNATURE | DATE (DD/MM/YY)

SUBMIT