Medical History

Name: _____ Today's date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

		Y	N
1.	Are you in good health?	☐	☐
2.	Have there been any changes in your general health within the past year?	☐	☐
3.	Date of your last physical exam:		
4.	Are you now under the care of a Physician/Naturopath?	☐	☐
5.	Physician/Naturopath Name Address : Phone # :		
6.	Have you ever been hospitalized for any surgical operation or serious illness? Please explain	☐	☐
7.	Are you taking any medicine including non-prescription medicine? If yes, please list:	☐	☐
8.	Have you had any abnormal bleeding?	☐	☐
9.	Do you bruise easily?	☐	☐
10.	Have you ever required a blood transfusion?	☐	☐
11.	Have you had a recent weight loss?	☐	☐
12.	Do you use tobacco?	☐	☐
13.	Do you use alcohol or cocaine or other drugs?	☐	☐
14.	Are you wearing contact lenses?	☐	☐
15.	Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Are you allergic to or have you had reaction to:

1.	Local anaesthetics like Novocain?	☐	☐
2.	Penicillin or other antibiotics?	☐	☐
3.	Sulpha drugs?	☐	☐
4.	Barbiturates, sedatives or sleeping pills?	☐	☐
5.	Aspirin?	☐	☐
6.	Other(s)?	☐	☐

	Do you have or have you ever had the following?	Y	N
1.	Rheumatic heart disease or rheumatic fever?	☐	☐
2.	Heart defect or heart murmur?	☐	☐
3.	Heart trouble, heart attack or angina?	☐	☐
4.	Pacemaker?	☐	☐
5.	Heart surgery?	☐	☐
6.	High blood pressure?	☐	☐
7.	Low blood pressure?	☐	☐
8.	Hepatitis, jaundice or liver disease?	☐	☐
9.	Stroke?	☐	☐
10.	Sinus trouble?	☐	☐
11.	Lung or breathing problems?	☐	☐
12.	Asthma or hay fever?	☐	☐
13.	Hives or skin rash?	☐	☐
14.	Fainting spells or seizures?	☐	☐
15.	Diabetes?	☐	☐
16.	AIDS or HIV infection?	☐	☐
17.	Thyroid problems?	☐	☐
18.	Arthritis or rheumatism?	☐	☐
19.	Joint replacement or implant?	☐	☐
20.	Stomach ulcer?	☐	☐
21.	Cancer?	☐	☐
22.	Sexually transmitted disease?	☐	☐
23.	Epilepsy?	☐	☐
24.	Anaemia?	☐	☐
25.	Leukemia?	☐	☐
26.	Glaucoma?	☐	☐

Women Only:

1.	Are you pregnant or think you may be pregnant?	☐	☐
2.	Are you nursing?	☐	☐
3.	Are you taking birth control pills?	☐	☐

Dental History

1. Reason for today's visit: _____

2. When was your last dental visit? _____

3. Who was your former dentist? _____

4. When were your last dental x-rays taken? ☐ within last 6 month ☐ 6 month – 1 yr ☐ 1 – 2 yr ☐ more than 2 years

5. Do you have amalgam (mercury) fillings in your mouth? ☐ yes ☐ no ☐ don't know

6. How old are these amalgam (mercury) fillings? ☐ Less than 2 yrs ☐ 2 – 5 yrs ☐ 5 – 10 yrs ☐ more than 10 yrs

7. How often do you brush your teeth? ☐ 1 x per day ☐ 2 x per day ☐ 3 x per day

8. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

		Y	N
9.	Do your gums bleed while brushing?	☐	☐
10.	Do your gums bleed when flossing?	☐	☐
11.	Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐
12.	Are your teeth sensitive to hold, cold, sweet or sour foods/liquids?	☐	☐
13.	Have you noticed any loosening of your teeth?	☐	☐
14.	Does food tend to become caught between your teeth?	☐	☐
15.	Do you have any sores or lumps in or near your mouth?	☐	☐
16.	Have you ever experienced any of the following problems in your jaw?		
	a. Clicking?	☐	☐
	b. Pain (joint, ear, side of face)?	☐	☐
	c. Difficulty in opening or closing?	☐	☐
	d. Difficulty in chewing?	☐	☐
17.	Have you had any head, neck or jaw injuries?	☐	☐
18.	Do you have frequent headaches?	☐	☐
19.	Do you clench or grind your teeth while awake or asleep?	☐	☐
20.	Do you bite your lips or cheeks frequently?	☐	☐
21.	Have you ever had:		
	a. Bridge work?	☐	☐
	b. Crown work?	☐	☐
	c. Partial denture?	☐	☐
	d. Root canal treatment?	☐	☐
	e. orthodontic treatment (braces)?	☐	☐
	f. Oral surgery?	☐	☐
	g. Gum treatment?	☐	☐
	h. Your bite adjusted?	☐	☐
	i. Worn a bite plane or other appliances?	☐	☐
22.	Are you satisfied with the appearance of your teeth?	☐	☐
23.	Have you ever had an upsetting experience in the dental office?	☐	☐
24.	Is there anything about having dental treatment that bothers you?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such dental care to third party payors and/or health practitioners.

_____ _____

Patient's or Guardian's Signature Date