STRATHROY DENTAL CENTRE

MEDICAL HISTORY FOR:

MO	DAY	YR

The following information is required by the dentist to assist in proper diagnosis and treatment. ALL INFORMATION IS CONFIDENTIAL.

		Yes	Don't Know Maybe	No
1.	Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐	☐
2.	Are you presently under the care of a physician?	☐	☐	☐
3.	Have you had a medical examination in the last year?	☐	☐	☐
4.	Do you use any prescription or non-prescription medications regulary? Specify:	☐	☐	☐
5.	Do you have any allergic condition, i.e. asthma, hay fever, skin rash, food allergies?	☐	☐	☐
6.	Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea? Specify:	☐	☐	☐
7.	Have you been hospitalized in the last 5 years?	☐	☐	☐
8.	Have you ever experienced any unusual reaction to any of the following: ☐ Local anaesthesia (freezing) ☐ Aspirin ☐ Penicillin ☐ Iodine ☐ Sulfonamide ☐ Barbiturates (sleeping pills)			
9.	Have you ever been warned against taking any drug or medication?	☐	☐	☐
10.	Do you have, or have you ever had, any of the following: ☐ Heart murmur or mitral valve prolapse ☐ Malignant hyperthermia ☐ AIDS ☐ Hepatitis A/B/C ☐ Liver disease ☐ Stomach/intestinal problems ☐ Drug/alcohol addiction ☐ Positive testing for HIV virus ☐ Herpes ☐ Cortisone/steroid therapy ☐ Joint replacement (hip, knee, etc.) ☐ Venereal disease ☐ Heart attack ☐ Mental or nervous disorder ☐ Any lung disease ☐ Jaundice ☐ Cold sores ☐ Other ☐ High/low blood pressure ☐ Thyroid disease ☐ Diabetes ☐ Cancer ☐ Hyper/hypo glycemia ☐ Arthritis or rheumatism ☐ Tuberculosis ☐ Kidney disease ☐ Epilepsy or seizures ☐ Scarlet or rheumatic fever ☐ Stroke ☐ Sinus trouble			
11.	Have you ever had any known contact with the AIDS virus?	☐	☐	☐
12.	Has any member of your family had diabetes?	☐	☐	☐
13.	Do you bruise easily or bleed abnormally?	☐	☐	☐
14.	Do your ankles swell during the day?	☐	☐	☐
15.	Have you had any weight changes recently?	☐	☐	☐
16.	Do you have any blood disorders such as anemia (thin blood), thalasseamia (major, minor)?	☐	☐	☐
17.	Have you ever had radiation treatment or chemotherapy? If so, explain:	☐	☐	☐
18.	Have you ever had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐	☐
19.	Do you have frequent severe headaches?	☐	☐	☐
20.	Do you have frequent earaches, ear/throat infections, or any hearing difficulties?	☐	☐	☐
21.	Is your eyesight: ☐ Good ☐ Adequate ☐ Poor Do you wear contact lenses?	☐	☐	☐
22.	Are you on a special diet?	☐	☐	☐
23.	Have you ever fainted?	☐	☐	☐
24.	Do you ever experience shortness of breath or chest pain when walking or climbing stairs? If so, explain:	☐	☐	☐
25.	Have you ever had any organ transplants or medical implants?	☐	☐	☐
26.	Do you have any disease, condition or problem that you think the doctor should know about? If so, explain:	☐	☐	☐
27.	Is there anything about yourself that we should be made aware of: If so, explain:	☐	☐	☐
28.	WOMEN ONLY – Are you pregnant? If so, what month are you in? – Are you taking any birth control pills?	☐ ☐	☐ ☐	☐ ☐

STRATHROY DENTAL CENTRE

DENTAL HISTORY FOR:

MO	DAY	YR

		Yes	Don't Know Maybe	No
1.	Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other Is there a dental problem you would like to have taken care of as soon as possible? Specify:	☐	☐	☐
2.	How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other Former dentist: Last dental visit: Last cleaning: Last full mouth x-rays: X-rays requested:			
3.	Have you been given oral hygiene instruction in: ☐ Brushing ☐ Flossing ☐ Other By whom?			
4.	Brushing: ☐ Vigorous ☐ Light How often?			
5.	How often do you floss your teeth?			
6.	Other cleaning aids used: ☐ Floss ☐ Stimudents ☐ Toothpaste ☐ Other			
7.	Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other			
8.	Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously			
9.	Is your sugar intake: ☐ High ☐ Medium ☐ Low			
10.	Have you ever had, or do you have, any of the following (please check) ☐ Bridges ☐ Lost fillings ☐ Bite appliance/night guard ☐ Gum treatments ☐ Partial dentures ☐ Extractions ☐ Swelling or pain in your mouth or jaw ☐ Gag easily ☐ Full dentures ☐ Loose teeth ☐ Difficulty opening or closing your jaw ☐ Root canal fillings ☐ Orthodontic treatment ☐ Injuries to your face or jaws ☐ Dental implants ☐ Bite adjustments ☐ Surgery to your mouth			
11.	Do you chew on only one side of your mouth? If so, where?	☐	☐	☐
12.	Does any part of your mouth hurt when clenched?	☐	☐	☐
13.	Does your jaw crack or pop when opened widely?			
14.	Do you have any pain in your ears?			
15.	Have you experienced any growth or sore spots in your mouth? If so, where?			
16.	Do you: • grind or clench your teeth during the day or night? • mouth breathe while awake or asleep? • bite your lips or cheeks regularly? • hold any foreign objects with your teeth (pipe, penciles, nails)? • smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other very good	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
17.	Check any of the following you are interested in or you have thought about: ☐ Orthodontics (braces) ☐ Repairing chipped teeth ☐ Improved gum health ☐ Bonding (straightening) ☐ Bleaching (whitening teeth) ☐ Improving your bite ☐ Closing spaces between teeth ☐ Crowns (caps) ☐ Improving breath odour ☐ Replacing missing teeth ☐ Sports mouth guard ☐ Improving your smile			
18.	Would your rate your current health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor			
19.	Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Embarrassment ☐ Other very good			

Comments:

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding the Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

☐ Patient (☐ parent, ☐ guardian) signature:

If parent, guardian*, please print name: Date (mm/dd/yyyy):

*Guardian of child or guardian of adult under guardianship

SUBMIT CLEAR FORM