80 Eastern Ave Unit 1
Brampton ON L6W 0B6
Phone: 905-450-7272
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MEDICAL HISTORY QUESTIONNAIRE

First Name: ____

Last Name: ____

Preferred Name: ___________________________________

Date of Birth (mm/dd/yy): __________________________

Male or Female: ___________________________________

Address: ____

____

Home Phone #: ____________________________________

Cell Phone #: _____________________________________

Family Doctor: ____________________________________

Office Phone #: ___________________________________

Address: ____

____

Emergency Contact: ________________________________

Phone #: ____

Relationship: ______________________________________

When was your last dental visit? ____

When was you last dental cleaning? ____

When did you last have dental xrays? ____

How often do you brush your teeth? ____

How often do you floss your teeth? ____

Have you been seeing a dentist regularly? ____

Do any of your teeth ache? ____

Are you grinding or clenching any of your teeth? ____________________________________

Do your gums bleed when you brush? ____

Do you have any pain when you chew? ____

Do you feel you have bad breath? ____

Have you ever been advised to take antibiotics before dental appointments? ______________

Have you ever been in a vehicle accident or experienced any blows to your jaw? ___________

Have you ever had any implant surgery in one or both of your jaws or jaw joints? __________

If yes to the above question, who performed the surgery and when was it done? ____________

Are you being followed up by a dental specialist? ___________________________________

Please list anything else not mentioned above regarding your past dental history: ___________

____

Do you have or have you ever had any of the following conditions? Please check all that apply.

__ Heart Attack	__ COPD/Chronic Bronchitis	__ Cancer _____________	__ Developmental Delay
__ Stroke/TIA	__ Shortness of Breath	__ Chemotherapy	__ Autism/ASD
__ Liver Disease	__ Asthma	__ Radiation Therapy	__ ADHD
__ Kidney Disease	__ High Blood Pressure	__ Leukemia	__ Visually Impaired
__ Diabetes	__ Low Blood Pressure	__ Psychiatric Disorder	__ Hearing Impaired
__ Chest Pain/Angina	__ Osteoporosis	__ Depression	__ Pacemaker
__ Stomach Ulcers	__ Steroid Therapy	__ Arthritis	__ Vertigo
__ Seizures/Epilepsy	__ Atrial Fibrillation	__ Sjogren's Syndrome	__ Chronic Neck/Back Pain
__ Hepatitis C	__ Heartburn/Gastric Reflux	__ Hypothyroid	__ Hyperthyroid
__ HIV/AIDS	__ Drug/Alcohol Dependence	__ Require a Wheelchair	__ Other _______________

Are you currently taking any medications, patches or inhalers? **Yes or No** (If yes, please list below)

____

____

____

____

MEDICAL HISTORY QUESTIONNAIRE

Are you allergic to any medications? (If yes, please list below) **YES or NO**

____

Do you have any other allergies? (if yes, please list below) **YES or NO**

____

Have you ever had:

A replacement or repair of a heart valve? (If yes, please list type below) **YES or NO**

____

An infection of the heart (endocarditis)? **YES or NO**

A heart condition from birth (congenital heart disease)? **YES or NO**

A heart transplant? **YES or NO**

Do you have a prosthetic or artificial joint? (If yes, please list location and date below) **YES or NO**

____

Do you have a bleeding problem or bleeding disorder? **YES or NO**

Do you take Coumadin, Warfarin, Dabigatran or Pradax? **YES or NO**

Do you smoke or chew tobacco products? **YES or NO**

If you quit smoking or using tobacco, when did you quit? ______________________

Are you breastfeeding or pregnant? **YES or NO**

Expected Due Date: ______________________

Are there any conditions or diseases not listed above that you have or had? **YES or NO**

____

Have you ever had any surgeries, major illnesses or hospitalizations? **YES or NO**

____

____

Does dentistry/dental treatment cause you anxiety? **YES or NO**

If yes, what makes you anxious about dentistry? ______________________

____

CHILDREN ONLY (Please check all that apply):

__ Childhood/Newborn Illness
__ Gastric Reflux/Heartburn
__ Sleeps/Slept with a Bottle
__ Drinks Pop or Juice Regularly
__ Asthma Inhalers
__ Premature Birth
__ Repeated Tonsillitis
__ Sour Candies
__ Drinks Gatorade/Sports Drinks
__ Repeated Strep Throat Infections
__ Difficulty Brushing/Flossing Teeth
__ Ear Aches/Ear Problems

TEENS/ADULTS ONLY (Please check all that apply):

__ Swish Pop Before Swallowing
__ Drink Mint Tea Frequently
__ Frequent Heartburn
__ Suck on Mints/Candies Weekly
__ Daily Coffee/Tea with Sugar
__ Suck Cough Drops Weekly
__ Drink Pop or Juice Daily
__ Drinks Gatorade/Sports Drinks
__ Drink Lemon Water Weekly
__ Difficulty Brushing/Flossing Teeth
__ Recent Pregnancy Within 3 Years

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

______________________ ______________________ ______________________

Patient Signature or Parent/Guardian Signature | Name of Parent/Guardian | Date