MEDICAL and DENTAL QUESTIONNAIRE - PLEASE PRINT

MEDICAL ALERT:

NAME: _____
Surname First Middle

Mr.◯/ Mrs.◯/ Miss◯/Ms.◯/ Master◯/ Dr.◯

MARITAL STATUS:

Single◯/Married◯/Divorced/◯/Widowed◯

DATE of BIRTH: Day _____ Month _____ Year _____

HOME ADDRESS:

_____

_____

_____Postal Code_____

PHONE NUMBER: Home _____

Cell _____

Business _____

E-MAIL ADDRESS: _____

OCCUPATION: _____

EMPLOYER: _____

REFERRED BY: _____

CONTACT PERSON IN CASE OF EMERGENCY

NAME: _____

RELATIONSHIP: _____

CONTACT PHONE: _____

PHYSICIAN

NAME: _____

OFFICE PHONE: _____

MEDICAL SPECIALIST

NAME: _____

SPECIALTY: _____

OFFICE PHONE: _____

PREVIOUS DENTIST

NAME: _____

OFFICE PHONE: _____

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 and explain any that you do not understand. PLEASE FILL IN THE ENTIRE FORM.

1. Are you currently being treated for any medical condition or have you been ◯YES ◯NO ◯NOT SURE
   within the past year? If yes, please specify. _____
2. When was your last medical checkup? _____
3. Has there been any change in your general health in the past year? ◯YES ◯NO ◯NOT SURE
   If yes, please specify. _____
4. Are you taking any medications, non-prescription drugs or herbal ◯YES ◯NO ◯NOT SURE
   supplements? If yes, please list names and dosage. _____
5. Do you have any allergies in the following categories? If you answer yes, please specify.
   a] medications ◯YES ◯NO ◯NOT SURE _____
   b] latex/rubber products ◯YES ◯NO ◯NOT SURE _____
   c] other (e.g. hayfever, foods) ◯YES ◯NO ◯NOT SURE _____

6. Have you ever had an unusual or adverse reaction to any medicines or ◯YES ◯NO ◯NOT SURE

Injections? If yes, please explain. _____

7. Do you have or have you ever had asthma? ◯YES ◯NO ◯NOT SURE

8. Do you have or have you ever had any heart or blood pressure problems? ◯YES ◯NO ◯NOT SURE

9. Do you have or have you ever had a replacement or repair of a heart ◯YES ◯NO ◯NOT SURE
valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

10. Do you have a prosthetic or artificial joint? If yes, when was the surgery? ◯YES ◯NO ◯NOT SURE

11. Do you have any conditions or therapies that could affect your immune ◯YES ◯NO ◯NOT SURE
system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

12. Have you ever had hepatitis, jaundice or liver disease? ◯YES ◯NO ◯NOT SURE

13. Do you have a bleeding problem or bleeding disorder? If yes, specify? ◯YES ◯NO ◯NOT SURE

14. Have you ever been hospitalized for any illnesses or operations? ◯YES ◯NO ◯NOT SURE

If yes, please explain. _____

15. Do you have or have you ever had any of the following conditions? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemeaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve	☐ lung disease	☐ diabetes	☐ kidney disease
☐ high blood pressure	prolapse			
☐ stroke, TIA	☐ heart murmur	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease
☐ shortness of breath		☐ cancer	☐ arthritis	☐ drug/alcohol dependency
☐ osteoporosis medications (e.g. Fosamax, Actonel)			☐ blood thinners	☐ venereal diseases

16. Are there any conditions or diseases not listed above that you have or ◯YES ◯NO ◯NOT SURE

have had? If yes, please specify. _____

17. Are there any diseases or medical problems that run in your family? ◯YES ◯NO ◯NOT SURE
(e.g. diabetes, cancer or heart disease)

18. Do you smoke or chew tobacco products or vape? ◯YES ◯NO ◯NOT SURE

19. Are you nervous during dental treatment? ◯YES ◯NO ◯NOT SURE

20. **For women only:** Are you breastfeeding or pregnant? ◯YES ◯NO ◯NOT SURE
If yes, what is the expected delivery date? _____

21. Do you identify as a patient with a disability? If yes, please explain. ◯YES ◯NO ◯NOT SURE

_____

To the best of my knowledge, the above information is correct. I consent to the performing of the dental procedures agreed to be necessary and advisable including the use of general and local anaesthetic as indicated. I also assume responsibility for the fees associated with those procedures.

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____