MEDICAL HISTORY QUESTIONNAIRE

RIDEAU LAKES DENTAL

NAME: MR./MISS/MRS./MS./DR.

First Last

DATE OF BIRTH (MONTH/DAY/YEAR): / /

ADDRESS (HOME):

City Province Postal Code

HOME PHONE:

CELL PHONE:

EMAIL:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

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 treated within the past year? If yes, please explain? ☐ Yes ☐ No ☐ Not Sure/Maybe

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.
☐ Yes ☐ No ☐ Not Sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below: ☐ Yes ☐ No ☐ Not Sure/Maybe

a) medications/latex/rubber products/other (e.g. hay fever, seasonal/environmental, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

7. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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

- ☐ None
- ☐ AIDS/HIV Positive
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety/ Nervous/ Depression
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve/ Pacemaker
- ☐ Artificial Joints (Hip, Knee, etc.)
- ☐ Asthma
- ☐ Bleeding Disorder/Problem
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diet (Special/Restricted)
- ☐ Drug/Alcohol Dependency
- ☐ Fainting or Dizzy Spells
- ☐ Gallbladder Disease
- ☐ GERD (Reflux)
- ☐ Heart (Surgery, Disease, Attack)
- ☐ Heart Infection
- ☐ Hepatitis A,B,C
- ☐ High/Low Blood Pressure
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease/Yellow Jaundice
- ☐ Lung Disease
- ☐ Kidney Trouble/ Disease
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psychiatric/Psychological Care
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizure Disorder/Epilepsy
- ☐ Shortness Of Breath
- ☐ Sinus Trouble
- ☐ Steroid Therapy (e.g Cortisone)
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

9. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

_____

10. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?
☐ Yes ☐ No ☐ Not Sure/Maybe

11. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe

12. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not Sure/Maybe

_____

14. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

_____

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

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____