Medical & Dental Questionnaire for New Patients

Last Name:	Given Names:	Date of Birth:
Name of Person Completing Form:		Relationship:
Mailing Address:	Email Address:	
City and Province:		Postal Code:
Home Phone #:	Business Phone #:	Cell Phone#:
Name of Emergency Contact:	Emergency Phone #:	Relationship:
Preferred Method of Contact:(Circle) Email Home Phone Business Phone Mail Cell Phone		

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

Health Questions:

Have you been examined or treated by a medical doctor in the last year? Yes No

If Yes, Reason For Seeking Medical Attention: _____

Name of Medical Doctor: _____ Doctor's Phone #: _____

Have you ever been seriously ill or hospitalized? Yes No

If Yes, please explain: _____

Have you ever experienced abnormal bleeding associated with a previous dental extraction, surgery or trauma? Yes No

Are you currently taking any medication, herbal remedies or non-prescription drugs? Yes No

If Yes, please list (with dosage): _____

_____

Do You Smoke or Use Chewing Tobacco? Yes No

If yes, how much/how often? _____

Do you have any allergies? Yes No

If Yes, please list: _____

_____

If Yes, do you carry an Epi-pen? Yes No

Have you ever been told to take prophylactic antibiotics before dental treatment? Yes No

Have you ever had any reactions or problems with anaesthetic or dental work? Yes No

If Yes, please explain: _____

Do you, or have you been told that you, snore? Yes No

Do you have, or have you ever had: (Check all that apply)

Rheumatic Fever		**Congenital Heart Condition**	
Heart Murmur		**Infective Endocarditis**	
Stroke or Heart Attack		**Joint Replacement**	
If Yes, when? *What is your INR?*		*If Yes, when?* *What joint?*	
Blood Pressure Issues		**Heart Issues**	
High or Low Blood Pressure? *Is it under control?*		*If Yes, what issues?* *Is it under control?*	
Kidney Issues		**Lung/Breathing Issues**	
If Yes, what issues? *Is it under control?*		*If Yes, what issues?* *Is it under control?*	
Stomach / Digestive Issues		**Diabetes**	
If Yes, what issues? *Is it under control?*		*If Yes, what type?* *Is it under control?*	
Blood Disorders		*What was your last reading?*	
If Yes, what disorder? *Is it under control?*		*How often do you check?*	
Sinus Issues		**Pacemaker/Artificial Valves**	
If Yes, what issues?		*If Yes, when was it placed?*	
Psychological/Stress Disorder?		**Epilepsy/History of Seizures**	
If Yes, what disorder? *Is it under control?*		*If Yes, how often do you have seizures?* *Is it under control?*	
Communicable Disease (AIDS, Hep C, etc)		**Thyroid Issues**	
If Yes, what disorder? *Is it under control?*		*If Yes, what issues?* *Is it under control?*	
Abnormal Tumors or Growths		**Women:** Are you, or could you be, pregnant?	

Is there any other health issue that we should be aware of? _____

Dental Questions:

What is your main dental concern? _____

Have you had regular dental care in a past? Yes No

What was the date of your last dental visit? _____

What was the purpose of your last dental visit? _____

What is the name of your former dentist? _____

How often did your previous dentist recommend you receive hygiene treatment? _____

Have you ever seen a dental specialist? Yes No

If Yes, what was the procedure? _____

What was the name of the specialist? _____

Do you have any para-functional oral habits such as clenching, grinding, ice chewing or nail biting? (Circle)

Have you ever received oral care instruction? Yes No

How often do you brush your teeth? _____ How often do you floss? _____

Are you satisfied with the function and appearance of your teeth? Yes No

Have you ever had a negative experience at the dentist? Yes No

If Yes, please explain: _____

Are you looking to obtain optimal oral health, optimal esthetics or a pain/disease free oral cavity? (Please Circle)

Patient or Guardian Signature_____ **Date:**_____