Waterloo FAMILY DENTAL

info@waterloofamilydental.ca 519.885.0930

Adult and Child Medical/ Dental History

Mr. /Mrs. /Ms. /Miss_____ Date of Birth ____/____/____
D M Y

Address: _____
Telephone: Home _____ Work_____ Cell_____
Your Email:_____ Your Employer: _____
Guardian/Partner's Name: _____ Family Physician and Phone Number: _____
Insurance Company Name, Policy and Certificate number: _____
Please contact me at: ☐ Work ☐ Home ☐ Email ☐ Any
Referred by: _____

Medical/ Dental Questionnaire

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaire. Please answer the questions as accurately as you can. If you have any questions or doubts, check the "not sure" choice. Your response will be reviewed with you by the dentist and you can be assured that the information will be kept in the strictest confidence.

	Yes	Not Sure	No
1. Are you being treated for any medical condition at the present or have you been treated within the last year?	☐	☐	☐
2. When was your last medical check-up? _____			
3. When was your last trip to the physician? _____			
Please give reason: _____			
4. Has there been any changes in your general health in the past year?	☐	☐	☐
5. Are you taking any medication or non-prescription drugs of any kind?	☐	☐	☐
If yes, please list them: _____			
6. Do you have any allergies?	☐	☐	☐
7. Have you even had a reaction to any medications or injections? (e.g. penicillin, aspirin or local anaesthetics "dental freezing")	☐	☐	☐
8. Do you have any heart of blood pressure problems?	☐	☐	☐
9. Do you have a heart murmur or mitral valve prolapse?	☐	☐	☐
10. Have you every had rheumatic fever?	☐	☐	☐
11. Do you have or have you ever had jaundice, hepatitis or liver disease?	☐	☐	☐
12. Have you ever been told that you should not give blood?	☐	☐	☐
13. Do you have any conditions that could affect your immune system (AIDS, HIV positive, leukemia, etc.)	☐	☐	☐
14. Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	☐	☐	☐
15. Have you ever been hospitalized for any serious illnesses or operations?	☐	☐	☐

If yes, please explain_____

16. Do you have or have you ever had any of the following? Check all that apply

☐ Chest pain	☐ Bronchitis	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Stroke
☐ Heart attack	☐ Diabetes	☐ Asthma
☐ Emphysema	☐ Prosthetic joint	☐ Stomach ulcers
☐ Kidney disease	☐ Drug/ alcohol dependency	

	Yes	Not Sure	No
17. Are there any conditions or disease not listed above that you have or have had?	☐	☐	☐
If yes, please explain _____			
18. Do you smoke or chew tobacco?	☐	☐	☐
19. Are you nervous about going to the dentist?	☐	☐	☐
20. For Women Only – Are you pregnant?	☐	☐	☐
If yes, what is your expected delivery date? _____			
21. When was your last dental visit? _____			
22. When did you last have dental x-rays? _____			
23. How often do you brush your teeth? _____			
24. How often do you floss your teeth? _____			
25. Do you use any other oral hygiene aids?			
26. Have you been seeing a dentist regularly?			
If so, how often? _____			
27. Do any of your teeth ache?	☐	☐	☐
28. Have you even been advised to take antibiotics before dental appointments?	☐	☐	☐
29. Do you gums bleed when you brush?	☐	☐	☐
30. Do you have any pain when you chew?	☐	☐	☐
31. Do you feel that you have bad breath?	☐	☐	☐
32. Have you ever been in a vehicle accident or experienced blows to your jaws?	☐	☐	☐
33. Have you ever had any implant surgery in one or both of your jaws or jaw joints?	☐	☐	☐
If yes, who performed the surgery and when was it done? _____			
34. Are you being followed-up by a dental specialist?	☐	☐	☐
35. Please list anything else not mentioned above regarding your past dental history or a present problem	☐	☐	☐

Follow-up Comments _____
_____ Reviewed By _____

Patient Certificate & Approval & Patient Consent

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary of advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associates with these procedures.

Patient (Parent, Guardian) Signature _____ Date _____

Medical Updates

Date	Changes	Signature