CRANSTON
DENTAL CENTRE

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME:

DATE OF BIRTH (DAY/MONTH/YEAR):

ADDRESS (HOME):

Postal Code

Home Phone

Work Phone

Cell Phone

Preferred Contact Phone

Email

OCCUPATION:

WHO MAY WE THANK FOR REFERRING YOU?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

CELL:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OR MEDICAL SPECIALIST:

AREA OF SPECIALTY:

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 being treated for any medical condition at the present or have you been treated within the past year? If so, why?

☐YES ☐NO ☐NOT SURE

2. When was your last **Medical** checkup?

3. Describe any current medical treatment, upcoming surgery or other treatments that may affect your dental treatment.

4. List any medications, supplements or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
a)		c)	
b)		d)	

5. Do you have any **allergies** (rash, hives, swelling) list the categoris below.

a) medications e.g. penicillin, aspirin
b) latex/rubber products
c) other e.g. hayfever, foods

☐YES ☐NO ☐NOT SURE

6. Have you ever had an **Adverse** reaction (nausea, dizziness) to any medications or injections? If yes please explain.

☐YES ☐NO ☐NOT SURE

(PLEASE COMPLETE OTHER SIDE)

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 condition or blood pressure problems?

☐YES ☐NO ☐NOT SURE

9. Do you have a prosthetic or artificial joint / heart valve?

☐YES ☐NO ☐NOT SURE

10 Do you have any conditions or therapies that could affect your immune system?
e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

☐YES ☐NO ☐NOT SURE

11. Have you ever had hepatitis, jaundice or liver disease?

☐YES ☐NO ☐NOT SURE

12. Do you have a bleeding problem or bleeding disorder?

☐YES ☐NO ☐NOT SURE

13. Have you ever been hospitalized for any illness or operations? If yes, please explain.

☐YES ☐NO ☐NOT SURE

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

☐ chest pain, angina	☐ shortness of breath	☐ cancer	☐ diabetes	☐ seizures	☐ drug/alcohol dependency
☐ heart attack	☐ lung disease	☐ radiation or chemotherapy	☐ stomach ulcers	☐ kidney disease	☐ depression
☐ stroke	☐ osteoporosis	☐ steroid therapy	☐ arthritis	☐ thyroid disease	
☐ pacemaker			☐ eating disorder		

15. Are there any conditions not listed above that you have had? If so, what.

16. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease)

☐YES ☐NO ☐NOT SURE

17. Do you smoke or chew tobacco products?

☐YES ☐NO ☐NOT SURE

18. Are you nervous during dental treatment?

☐YES ☐NO ☐NOT SURE

19. **For women only**: Are you breast-feeding or pregnant?
If pregnant, what is the expected delivery date?

☐YES ☐NO ☐NOT SURE

To the best of my knowledge, the above information is correct. I also consent to the collection, use, or disclosure or personal information as is required for my own and my dependents dental care.

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE**

DENTIST SIGNATURE: **DATE**

DENTIST'S NOTES