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Medical History

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

a) medications ____

b) latex/rubber products ____

c) other (e.g. hay fever seasonal/environmental, foods) _______________________________________

2. Are you taking any Blood Thinning Medication? If Yes, List below: Yes No Not Sure/Maybe

____

3. Are you on Osteoporosis and/or Bone Medication? If Yes, List below: Yes No Not Sure/Maybe

____

4. Do you have, or have you suffered or been treated for any form of depression, stress or psychiatric condition?
 Yes No Not Sure/Maybe

5. Do you have any condition or therapies that could affect your immune system (e.g. Leukemia, AIDS, HIV infection, radiotherapy, Chemotherapy)? Yes No Not Sure/Maybe

6. Do you have a prosthetic or artificial joint? Yes No Not Sure/Maybe

7. Do you have, or have you ever had an artificial heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital hear disease) or a heart transplant?
 Yes No Not Sure/Maybe

8. Are you being treated for any medical condition at present or have you been treated within the past year? If so why?
____ Yes No Not Sure/Maybe

9. Have you ever been hospitalized for any illnesses or operations, including plastic surgery? If yes, please explain

____ Yes No Not Sure/Maybe

10. When was your last medical check up? ____

11. Has there been any change in your general health in the past year? If yes, please explain.

____ Yes No Not Sure/Maybe

12. Are you taking any medications, non- prescription drugs or herbal supplements of any kind: **if yes please list:**

____ Yes No Not Sure/Maybe

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13. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

____ ☐ Yes ☐ No ☐ Not Sure/Maybe

14. Do you have, or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

15. Do you have, or have you ever had any heart or blood problems? ☐ Yes ☐ No ☐ Not Sure/Maybe

16. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

17. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

18. Do you have, or have you ever had any of the following? **Please check**:

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

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

____ ☐ Yes ☐ No ☐ Not
Sure/Maybe

20. Are there any diseases or medical problems that run in your family? ☐ Yes ☐ No ☐ Not
Sure/Maybe

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

22. For women only: Are you breastfeeding or Pregnant? If pregnant, what is the expected delivery date?

____ ☐ Yes ☐ No ☐ Not
Sure/Maybe

Note: There are drugs used in routine dental care that decreases the effectiveness of birth control pills

23. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not

DENTISTS NOTES:

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DENTAL HISTORY

1 What is the reason for your visit today? Are you currently experiencing any dental problems?

____

2. Have you been seeing a dentist regularly? If not, why not? ◯ Yes ◯ No ◯ Not Sure/Maybe

____

3. Are you nervous during dental visits? ◯ Yes ◯ No ◯ Not Sure/Maybe

4.Have you had a bad experience or complications during dental treatment? ◯ Yes ◯ No ◯ Not Sure/Maybe

5. When was your last dental visit? What was done at that appointment?

____

6. When did you last have dental x-rays? ____

7. Have you ever seen a dental specialist? ◯ Yes ◯ No ◯ Not Sure/Maybe

8. How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

____

9. **Have you ever been told to take an antibiotic prior to dental procedures? ◯ Yes** ◯ No ◯ Not Sure/Maybe

10. Do you feel that you have bad breath? ◯ Yes ◯ No ◯ Not Sure/Maybe

11. Are you happy with the appearance of your teeth? ◯ Yes ◯ No ◯ Not Sure/Maybe

12. Do you have any problems with your jaw (clicking, limited movement, pain)? ◯ Yes ◯ No ◯ Not Sure/Maybe

13. Have you had pain or clicking in the jaw joint around your ear? ◯ Yes ◯ No ◯ Not Sure/Maybe

14. Have you ever had an injury to the teeth or jaws or been in a motor vehicle accident?

Yes No Not Sure/Maybe

15. **Have you experienced dry mouth or a burning sensation of the mouth or tongue?**
Yes No Not Sure/Maybe

16. **Have you ever had a serious injury to your head or neck or suffered from neck pain?**
Yes No Not Sure/Maybe

17. **Have your face muscles ever been sore?** Yes No Not Sure/Maybe

18. Have you ever fainted? Yes No Not Sure/Maybe

19. **Have you had an allergic reaction?** Yes No Not Sure/Maybe

20. **Have you had abnormal bleeding?** Yes No Not Sure/Maybe

21. Have you had any complications during or following a dental procedure? If yes, describe:

____ Yes No Not Sure/Maybe

22. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? Yes No Not Sure/Maybe

23. Are your teeth sensitive to hot, cold or pressure? Yes No Not Sure/Maybe

24. Do you grind or clench your teeth? Yes No Not Sure/Maybe

25. Do you wear a night guard? Yes No Not Sure/Maybe

26. Are there any sores or growths in your mouth? Yes No Not Sure/Maybe

Dentist Notes:

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

PATIENT/GUARDIAN SIGNATURE: ______________________________________ DATE: ________________

DENTIST SIGNATURE: _______________________________________ DATE: ________________