NEWEST smile dental

# Medical & Dental History

First and Last Name: _____

Date of Birth: Y____/M____/D____ ◯ Male ◯ Female Phone #: Home _____ Cell _____

Home Address: _____

City/Province: _____ Postal Code: _____ E-mail: _____

Person to notify in case of emergency: _____ Phone Number: _____

**How did you hear of us?** ☐ 123 Website ☐ Live in Village ☐ Patient Referral ☐ Google ☐ Radio ☐ Other

## MEDICAL HISTORY QUESTIONNAIRE

Have you ever had minimal or moderate sedation? ◯ Yes ◉ No If yes, When? _____

Any complications? ◯ Yes ◉ No If yes, please explain _____

Any history of family sedation/anesthetic complications? ◯ Yes ◉ No If yes, please explain _____

Are you presently being treated for any medical condition or have you been in the past 2 years? ◯ Yes ◉ No

If yes, please explain _____

When was your last visit to a physician?_____ Last complete medical examination? _____

Have you been hospitalized in the last five years? ◯ Yes ◉ No

If yes, please explain _____

**Are you taking any prescription or non-prescription drugs?** ◯ Yes ◉ No

If yes, please specify drug(s), dosage(s) and for how long? _____

_____

**Have you ever had a reaction to any drug(s) or been advised against taking any kind of medication?** ◯ Yes ◉ No

If yes, please explain (e.g., penicillin, sulpha, codeine) _____

Do you have any sensitivities or allergies? ◯ Yes ◉ No If yes, please explain _____

Do you have any history of family disease? ◯ Yes ◉ No If yes, please explain _____

Do you smoke or use other forms of tobacco? ◯ Yes ◉ No If yes, number/day and for how many years _____

Do you have a history of alcohol and/or drug abuse? ◯ Yes ◉ No

Have you received treatment for alcohol or drug use? ◯ Yes ◉ No

Do you currently have, or have you had in the past, any disease, condition or problem not listed? ◯ Yes ◉ No

If yes, please explain _____

Is there any problem or medical condition that you wish to discuss in private with the dentist? ◯ Yes ◉ No

WOMEN ONLY: Are you pregnant or suspect you might be? ◯ Yes ◉ No Anticipated delivery date?_____

Are you breast feeding? ◯ Yes ◉ No

Are you taking birth control pills? ◯ Yes ◉ No

## Indicate which of the following you presently have or have ever had:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ◯ | ◉ | Alzheimers | ◯ | ◉ | Blood disorders | ◯ | ◉ | Congestive heart failure |
| ◯ | ◉ | Anemia | ◯ | ◉ | Blood in Sputum | ◯ | ◉ | Cortisone/steroid therapy |
| ◯ | ◉ | Angina pectoris | ◯ | ◉ | Bronchitis | ◯ | ◉ | Diabetes |
| ◯ | ◉ | Arthritis/rheumatism | ◯ | ◉ | Cancer | ◯ | ◉ | Earaches (frequent) |
| ◯ | ◉ | Artificial heart valve | ◯ | ◉ | Cerebral palsy | ◯ | ◉ | Emphysema |
| ◯ | ◉ | Artificial joints | ◯ | ◉ | Changes in appetite | ◯ | ◉ | Epilepsy or seizures |
| ◯ | ◉ | Asthma | ◯ | ◉ | Chest pains | ◯ | ◉ | Fainting or dizzy spells |
| ◯ | ◉ | Balance problems | ◯ | ◉ | Circulation problems | ◯ | ◉ | Glandular disorders |
| ◯ | ◉ | Bleed easily | ◯ | ◉ | Congenital heart lesions | ◯ | ◉ | Glaucoma |
| ◯ | ◉ | AIDS | ◯ | ◉ | Hypertension | ◯ | ◉ | Psychiatric treatment |
| ◯ | ◉ | Headaches (severe) | ◯ | ◉ | Impaired vision | ◯ | ◉ | Radiation or chemotherapy treatment |
| ◯ | ◉ | Head/neck injuries | ◯ | ◉ | Infective endocarditis | ◯ | ◉ | Rheumatic/Scarlet fever |
| ◯ | ◉ | Hearing difficulties | ◯ | ◉ | Jaundice | ◯ | ◉ | Shortness of breath |
| ◯ | ◉ | Heart disease or attack | ◯ | ◉ | Kidney disease | ◯ | ◉ | Sickle cell disease |
| ◯ | ◉ | Heart murmur | ◯ | ◉ | Leukemia | ◯ | ◉ | Sinus trouble |
| ◯ | ◉ | Heart pacemaker | ◯ | ◉ | Liver disease | ◯ | ◉ | Stomach/intestinal problems |
| ◯ | ◉ | Heart rhythm disorder | ◯ | ◉ | Lung disease | ◯ | ◉ | Stroke |
| ◯ | ◉ | Heart surgery | ◯ | ◉ | Malignant hyperthermia | ◯ | ◉ | Temperature intolerance |
| ◯ | ◉ | Hemophilia | ◯ | ◉ | Medical implant | ◯ | ◉ | Thyroid disease |
| ◯ | ◉ | Hepatitis A | ◯ | ◉ | Mental/Nervous disorder | ◯ | ◉ | Tuberculosis |
| ◯ | ◉ | Hepatitis B | ◯ | ◉ | Mitral valve prolapse | ◯ | ◉ | Ulcers |
| ◯ | ◉ | Hepatitis C | ◯ | ◉ | Nosebleeds (frequent) | ◯ | ◉ | Venereal disease |
| ◯ | ◉ | Herpes | ◯ | ◉ | Organ transplant | ◯ | ◉ | Weight gain/loss |
| ◯ | ◉ | High/low blood pressure | ◯ | ◉ | Persistent cough | ◯ | ◉ | Other _____ |
| ◯ | ◉ | Hodgkin's disease | ◯ | ◉ | Pulmonary edema | | | |
| ◯ | ◉ | Hyperglycemia | ◯ | ◉ | HIV positive | | | |

## NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted, if necessary, to obtain information that is required for my dental care.

Signature: _____ Date: _____

Reviewed by dentist: _____ Date: _____