MEDICAL HISTORY

Name_____ Birth Date (Y/M/D)_____

Address_____ P Code_____

Hm_____Wk_____Cell_____ Care Card_____-_____-_____

Email_____ Best Contact hm / wrk / cell / email

Spouse_____Wk_____Cell_____EContact_____Rel_____Ph_____

Mom_____Wk_____Cell_____ Dad_____Wk_____Cell_____

Employer_____ Family Physician_____ Prev Dentist_____

1. Have you ever had surgery? If so, for what reason and what year? _____

   _____

2. Have you been hospitalized or under the care of a physician within the last two years? If so, for what reason?

   _____

3. Are you currently taking any medications or tablets? If so, what? _____

   _____

4. Have you taken cortisone or steroids within the last 2 years? _____
5. Are you allergic or hypersensitive to anything, drugs or otherwise (eg. Penicillin, latex)? _____

   _____

6. Do you take or have you recently discontinued taking any of the following: (Please circle)

   Echinacea Ephedra Feverfew Garlic Ginseng Ginger Ginko Biloba Kava Kava Licorice St John's Wort Valerian Vitamin D Supplements

7. Do you have or have you ever had: (Please circle)

   Abnormal Heart Condition Tuberculosis/Asthma Arthritis Epilepsy Ulcers Anemia Diabetes High Blood Pressure/Stroke Jaundice / Hepatitis Venereal Disease Psychiatric Treatment/Depression Heart Murmur/Rheumatic Fever

8. Have you or anyone in your family ever had problems with bleeding?_____
9. Are you or might you be pregnant? _____
10. Have you been advised that you may be at risk for HIV / Hepatitis? _____
11. Have you or anyone in your family had a problem with general or local anesthetic? If yes, what was the reaction?_____
12. Do you have an artificial heart valve or joint replacement eg: hip or knee?_____
13. Do you use tobacco products? If so, which ones and how much? _____
14. Is there any condition not mentioned above of which we should be aware? _____

Please note that it is our policy to receive two working days notice for an appointment change otherwise a rescheduling fee may be applied of $108 for reserved chair time.

Patients are responsible for any service fees not covered by their insurance provider(s).

Patient(Parent/Guardian):_____-_____ Date: _____ Reviewed by:_____

20__/__/__: _____

20__/__/__: _____

20__/__/__: _____

20__/__/__: _____

DENTAL HISTORY

What is your immediate dental concern? _____

_____

When was your last check-up and cleaning appointment? _____

Have you ever had orthodontic treatment? If so when? _____

Please check if you have or are concerned about any of the following:

1. _____ Displeasure with the appearance of your teeth.
2. _____ A previous unfavorable dental experience.
3. _____ Dental fears.
4. _____ Problems with effectiveness or bad reactions to anesthetic.
5. _____ Bleeding gums.
6. _____ Areas of your mouth that you avoid brushing.
7. _____ Areas of your mouth that are sensitive to temperature.
8. _____ Sore teeth.
9. _____ A burning sensation in your mouth.
10. _____ Jaw problems.
11. _____ An unpleasant taste or odor in your mouth.
12. _____ Difficulty opening your mouth widely.
13. _____ Clicking or popping in your jaw.
14. _____ Awakening with an awareness of your teeth or jaw.
15. _____ Clenching or grinding of your teeth.
16. _____ Missing teeth.
17. _____ Food trapping between your teeth.
18. _____ Tensions headaches.
19. _____ Stiff neck muscles.

SUPPLEMENTAL DENTURE HISTORY

If you wear a complete or partial denture, please complete the following.

When did you receive your first partial or complete denture? _____

Is your present denture a problem? Describe. _____

Has your present denture been relined? If yes, when? _____

Are you satisfied with your denture's appearance? If not describe. _____

_____

Are you satisfied with the comfort of your dentures? If not describe._____

_____

Are you satisfied with its chewing ability? _____

_____