VILLAGE
Dental Centre

Medical History Questionnaire

NAME: _____

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME): _____

_____

HOME PHONE: _____

CELL: _____

EMAIL: _____

NAME OF EMPLOYER: _____

PHONE: _____

OCCUPATION: _____

WHO REFERRED YOU TO OUR OFFICE? _____

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE: _____

INSURANCE COMPANY: _____

GROUP/PLAN NUMBER: _____

CERTIFICATE/ID NUMBER: _____

WHOSE INSURANCE IS IT AND THEIR DATE OF BIRTH: _____

_____

_____

_____

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/Maybe

_____

2. When was your last medical checkup?

_____

3. Has there been any change in your general health in the past year, such as surgeries or hospitalizations?
If yes, please explain. ❑ Yes ❑ No ❑ Not Sure/Maybe

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
❑ Yes ❑ No ❑ Not Sure/Maybe

_____

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

a) medications (e.g. penicillin/sulfa/codeine/aspirin/local anaesthetic)
b) latex/rubber products
c) other (e.g. hayfever, foods)

_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❑ Yes ❑ No ❑ Not Sure/Maybe

_____

7. Do you have or have you ever had asthma? ❑ Yes ❑ No ❑ Not Sure/Maybe

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8. Do you have or have you ever had any heart or blood pressure problems?
❑ Yes ❑ No ❑ Not Sure/Maybe

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

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

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11. 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/Maybe

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

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

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14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
❑ Yes ❑ No ❑ Not Sure/Maybe

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

❑ diabetes	❑ shortness of breath	❑ tuberculosis	❑ steroid therapy	❑ osteoporosis medications
❑ chest pain, angina	❑ stroke	❑ kidney disease	❑ stomach ulcers	(e.g. Fosamax, Actonel)
❑ heart attack	❑ cancer	❑ seizures(epilepsy)	❑ drug/alcohol dependency	❑ malignant hyperthermia
❑ pacemaker	❑ lung disease	❑ organ transplant	❑ arthritis	

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16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
❑ Yes ❑ No ❑ Not Sure/Maybe

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17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
❑ Yes ❑ No ❑ Not Sure/Maybe

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18. Do you smoke or chew tobacco products? ❑ Yes ❑ No ❑ Not Sure/Maybe
How much per day? How many years?

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19. Are you nervous during dental treatment? ❑ Yes ❑ No ❑ Not Sure/Maybe

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20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
❑ Yes ❑ No ❑ Not Sure/Maybe

Village Dental Centre requires 48 hrs notice to cancel an appointment. A cancellation fee of $50 will be applied to your account if such notice is not received.

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

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

DENTIST SIGNATURE: _____ **DATE:** _____