MEDICAL HISTORY QUESTIONNAIRE

The following information is required by the Dentist to assist in proper diagnosis and treatment. Please feel free to ask the receptionist for help in completing this form. *PLEASE PRINT.*

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Dr. Samson Lee
Credit River Dental Centre
114 Lakeshore Rd. E.
Port Credit, ON L5G 1E4
T: (905) 278 - 4297

Date (M/D/Y) _____

MEDICAL ALERT

PATIENT

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name: _____
(last) (first) (initial)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
(month/day/year)

Home Address: _____
(apt./suite #) (street) (city) (province) (postal code)

Medical History:

1. Are you currently being treated for any medical condition, 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 to your general health in the past year? 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 answer yes, please list using the categories below: ☐ Yes ☐ No ☐ Not Sure/Maybe
   a) Medications:
   b) Latex/rubber products:
   a) Other (e.g. hay fever, 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

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

9. 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 heart disease) or a heart transplant? ☐ Yes ☐ No ☐ Not Sure/Maybe

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

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

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

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

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

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

☐ Chest Pain, angina	☐ Rheumatic fever	☐ Steroid therapy	☐ Seizures (Epilepsy)	☐ Osteoporosis medications (e.g. Fosamax, Actonel)
☐ Heart attack	☐ Mitral valve prolapse	☐ Diabetes	☐ Kidney disease	
☐ Stroke	☐ Heart murmur	☐ Stomach ulcers	☐ Thyroid disease	
☐ Shortness of breath	☐ Pacemaker	☐ Arthritis	☐ Drug/alcohol dependancy	

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

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

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

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

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

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

Signature: _____ _____

☐ PATIENT ☐ PARENT ☐ GUARDIAN (Print name of Guardian)

Reviewed by treating Dentist: _____ **Date:** _____ (month/day/year)

DENTIST'S NOTES