YORKVILLE DENTAL

Medical History Questionnaire

Medical Alert: **Date:**

Name (MR. / MISS / MRS. / MS. / DR. / MX.): Date of Birth (DAY/MONTH/YEAR): _____/_____/_____ Phone:_____ Email :_____ Insured Member: _____ Insurance Plan Name/Company: _____ Insurance Plan/Contract Number: _____ Insurance Certificate/ID Number: _____	Address (Street Number, Street, City, Province, Postal Code): _____ _____ _____ _____ Emergency Contact (Name, Relationship, Phone Number): _____ _____ Family Doctor (Name, Phone Number): _____ Preferred Pharmacy (Name, Phone Number): _____ How did you hear about our office?: _____

The following information is required to provide you with the best possible dental care. All information is strictly private, protected by doctor-patient confidentiality. The dentist will review the information and explain anything that you do not understand. Please fill in the entire form completely.

1. Are you currently being treated for any medical condition or have you been treated within the past year?
If yes, please explain? ❒ Yes ❒ No ❒ Not Sure/Maybe

_____

2. When was your last medical checkup? When was your last dental cleaning?

_____

3. Has there been any change in 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 them. ❒ Yes ❒ No ❒ Not Sure/Maybe

_____

_____

5. Do you have any allergies? ❒ Yes ❒ No ❒ Not Sure/Maybe
If yes, please list them using the categories below:
a) medications (sulfa, antibiotics, codeine, etc.):_____
b) latex/rubber products: _____
c) other (e.g. hay fever, seasonal/environmental, 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, tuberculosis, 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.
❒ 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 dependency ❒ osteoporosis medications (e.g. Fosamax, Actonel)

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16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
❒ 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

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

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20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
❒ Yes ❒ No ❒ Not Sure/Maybe

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21. Do you identify as a patient with a disability? If yes, please explain so we can better suit your needs.
❒ Yes ❒ No ❒ Not Sure/Maybe

To the best of my knowledge, the above information is complete and correct

*Patient/Parent/Guardian Signature:*_____ *Date:*_____

*Dentist Signature:*_____ *Date:*_____

DENTIST'S NOTES: