MACNEILL | SPINNATO

FAMILY DENTISTRY

PREVENTATIVE | COSMETIC | SURGICAL

# Medical History Questionnaire

Medical Alert: _____

Mr. / Mrs. / Miss. / Ms. / Dr. (please circle)

Name: _____

Date of Birth: (D / M / Y) _____

Address (Home):

_____

_____

Phone: _____

OHIP Number: _____

Name of Employer: _____

Insurance Company: _____

Contract Number: _____

Certificate Number: _____

**IN CASE OF EMERGENCY, WE SHOULD NOTIFY:**

Name: _____

Relationship: _____

Daytime Phone: _____

**PHYSICIAN:**

Family Doctor: _____

**SPECIALIST (if applicable):**

Name of Specialist: _____

Area of Specialty: _____

Phone: _____

Who may we thank for your referral? _____

**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 PATIENT-DOCTOR CONFIDENTIALITY. THE DENTIST AND HIS TEAM 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 time or have you been treated within the past year? If so, please explain?
☐ 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? I f yes, please explain. ☐ Yes ☐ No ☐ Not sure/maybe

_____

**4.** Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If so, please list. ☐ Yes ☐ No ☐ Not sure/maybe

_____

**5.** Do you have any allergies? If yes, please list using the categories below: ☐ Yes ☐ No ☐ Not sure/maybe

*1. Medications* _____

*2. Latex/ rubber products* _____

*3. Other (e.g. hay fever or foods)* _____

**6.** Have you ever had a peculiar or adverse reaction to any medications 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 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

**10.** Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not sure/maybe

**11.** Have you been advised by your doctor or specialist to take pre-treatment antibiotics for dental appointments? ☐ Yes ☐ No ☐ Not sure/maybe

**12.** Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy or chemotherapy?
☐ Yes ☐ No ☐ Not sure/maybe _____

**13.** Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not sure/maybe

**14.** Do you have a bleeding problem or disorder? ☐ Yes ☐ No ☐ Not sure/maybe

**15.** Have you ever been hospitalized for any illness or operation? If so, please explain. ☐ Yes ☐ No ☐ Not sure/maybe

_____

**16.** Do you have any of the following? Please check boxes.

| | | | | | |
|---|---|---|---|---|---|
| ☐ chest pains or angina | ☐ rheumatic fever | ☐ pacemaker | ☐ steroid therapy | ☐ seizures (epilepsy) | ☐ osteoporosis medications (e.g. Fosamax, Actonel) |
| ☐ heart attack | ☐ mitral valve prolapse | ☐ lung disease | ☐ diabetes | ☐ kidney disease | |
| ☐ stroke | ☐ tuberculosis | ☐ stomach ulcers | ☐ thyroid disease | ☐ shortness of breath | |
| ☐ heart murmur | ☐ cancer | ☐ arthritis | ☐ drug/alcohol dependency | | |

**17.** Are there any conditions or diseases not listed above that you have or have had? If yes, please explain. ☐ Yes ☐ No ☐ Not sure/maybe

_____

**18.** Are there any diseases or medical conditions that run in your family? (E.g. diabetes, cancer or heart disease) If yes, please explain.
☐ Yes ☐ No ☐ Not sure/maybe

_____

**19.** Do you smoke or use any chewing tobacco products? ☐ Yes ☐ No ☐ Not sure/maybe

**20.** Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure/maybe

_____

**FOR WOMEN ONLY:** Are you pregnant? ☐ Yes ☐ No ☐ Not sure/Maybe If yes, how many weeks? _____
Are you breastfeeding? ☐ Yes ☐ No

**TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT:**

Patient /Parent/ guardian signature: _____ Date: _____

Dentist's Signature: _____ Date: _____