BROOKVIEW DENTAL CLINIC Medical/Dental History Questionnaire

1. PATIENT INFORMATION

First Name: ________________________________ Last Name: ____

Title: Dr. Mr. Mrs. Ms. Miss Master (circle)

Date of Birth: __________________________ Gender: _________ Occupation: ___________________________

Marital Status: Single Married Common-Law Separated Divorced (circle)

Address: ________________________________ City: ______________ Province: _____ Postal Code: _________

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ___________________

Email: ____ Reminder preference? Text Email Phone (circle)

How did you hear about our office? ____

Emergency Contact (Parent name for minors)

Name: _____________________________ Relationship: ________________ Phone Number: _______________

The following information is required to help us provide you with the best possible dental care. All information is kept confidential and is protected by the Personal Information Protection and Electronic Documents Act (PIPEDA).

2. DENTAL HEALTH HISTORY

When was your last full dental exam?	When were your last dental x-rays taken?
When was your last professional dental cleaning?	How often do you brush?
Do you use an electric toothbrush?	How often do you floss?
Please list any dental concerns or things you'd like to change about your teeth/smile:	Previous dentist name and phone number:

Please check YES or NO for the following:

	Y	N		Y	N
Have you had orthodontic treatment/braces?			Do you think you clench or grind your teeth?		
Have you had periodontal (gum) surgery or treatment?			Do you wear a night guard/splint?		
Have you had orthagnathic (jaw) surgery?			Do you wear removable orthodontic retainers?		
Are your teeth sensitive to cold, hot, pressure, or sweets?			Do you wear dentures (full or partial)?		
Do your gums frequently bleed when brushing?			Do you have any dental implants?		
Do you think you may suffer from TMJ dysfunction?			Do you have any oral piercings?		
Do you suffer from frequent headaches?			Have you ever had a head or neck injury?		
Do you feel you have bad breath?			Do you have a dry mouth?		
Do you have sinus issues?			Do you bite your nails/other oral habits?		
Do you snore or have sleep apnea?			Are you nervous about dental treatment?		
Do you wear a CPAP or oral snoring appliance?			Do you have trouble lying back in the dental chair?		
Are you a mouth breather?			Would you like a neck pillow in the dental chair?		

If you said YES to any of the above or you have any other dental/oral condition not listed please elaborate:

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3. MEDICAL HISTORY

When was your last medical exam and reason for the visit?	Family physician name and phone number

Please check YES or NO for the following:

	Y	N		Y	N
Have you had any major changes in your health or any new treatments for medical concerns in the past two years?			Do you vape? If YES, how often?		
Have you been hospitalized for any illness or surgery in the past five years?			Do you smoke marijuana? If YES, how often?		
Do you have any **allergies or negative reactions** to medications? (e.g. to penicillin, codeine, aspirin, ibuprofen, sulpha drugs, local anesthetics and the reaction)			Do you smoke cigarettes, pipes or cigars? If YES, how much per day and for how many years?		
Do you have any other **allergies**? (e.g. to latex, food, animals, etc. and the reaction)			Do you chew tobacco or betel nuts? If YES, how often?		
Have you been advised to take antibiotics prior to dental treatment for a condition (not including treatment for an active dental infection)?			**WOMEN:** Are you pregnant or breastfeeding? If pregnant, how many weeks?		

Are you taking any medications, including prescription, over the counter, and supplements? If YES, please list:

Drug or Supplement Name	Amount, Dosage, Frequency	Reason for Taking

Please indicate which of the following you have had in the past or currently have:

	Y	N		Y	N		Y	N
Cardiovascular/Respiratory			**Haematological (Blood)**			Crohn's disease or Colitis		
Angina			Blood transfusion			Stomach ulcers		
Artificial heart valve replacement			Abnormal bleeding/blood disorder			Kidney disease		
Congenital heart defects			Abnormal bruising			Organ Transplant (liver/kidney)		
Chest pain			**Immune System/Infectious Disease**			**Neurological/Muscular/Skeletal**		
Heart disease			Cancer (Type? __________________)			Stroke		
Heart attack			Chemotherapy			Seizure disorder/Epilepsy		
Heart surgery			Radiation (Site? _________________)			Neurological disorder		
Heart transplant			Systemic lupus erythematosus			Arthritis/Rheumatoid arthritis		
Heart stent			Steroid therapy			Joint replacement (knee, hip)		
Heart murmur			Cold sores			Osteoporosis		
Infective endocarditis			HIV/AIDS			**Mental Health/Other**		
Pacemaker			Hepatitis A, B, or C			Anxiety		
Shortness of breath			**Endocrine/Digestion/Gastrointestinal**			Depression		
Swollen ankles			Diabetes (Type?__________________)			Schizophrenia		
High blood pressure			Thyroid problems			Drug or alcohol dependency		
Low blood pressure			Celiac disease			Other mental health issue		
Asthma			Eating disorder			Blind/Visually impaired		
Tuberculosis			Liver disease/Jaundice			Deaf/Hearing impaired		
Emphysema/Chronic bronchitis/COPD			Acid reflux			Latex sensitivity		

Any other conditions not listed: ____

I certify that I have provided an accurate and complete personal and medical history for myself or my minor child and that I have not knowingly omitted any information.

Name: ______________________________ Relationship (if signing for a minor): ____________________

Signature: ______________________________ Date: ____________________