r.a.campbell
DENTISTRY

112 King Street East Bowmanville ON L1C 1N5
(905) 623-9383 fax (905) 623-9331
drcampbell@hotmail.ca

MEDICAL HISTORY QUESTIONNAIRE

NAME:

DATE OF BIRTH (D/M/Y) __ / _ / ____

ADDRESS: _____

_____

POSTAL CODE _____

E-MAIL ADDRESS _____

HOME PHONE: ( ) CELL ( ) WORK( )

OCCUPATION: _____

MEDICAL ALERT:

IN CASE OF EMERGENCY WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

FAMILY DOCTOR: _____

MEDICAL SPECIALIST: _____

AREA OF SPECIALTY _____

WHO REFERRED YOU TO OUR OFFICE? _____

Would you like to receive text message or email reminders regarding your upcoming dental appointments?

YES NO NOT SURE/MAYBE

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 presently or within the past year? If so, why? YES NO NOT SURE/MAYBE

2. When was your last medical check-up? _____

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? If yes, please explain. 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 _____
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

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. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, aids, HIV, radiotherapy, chemotherapy?
☐ YES ☐NO ☐NOT SURE/MAYBE

12. Have you ever had jaundice, liver disease or Hepatitis? Type A B C (please circle)
☐ YES ☐NO ☐NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder?
☐ 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

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

☐chest pain, angina	☐rheumatic fever	☐pacemaker	☐steroid therapy	☐seizures (epilepsy)
☐osteoporosis	☐heart attack	☐lung disease	☐diabetes	☐ kidney disease
☐tuberculosis	☐stomach ulcers	☐stroke	☐ thyroid disease	☐arthritis
☐shortness of breath	☐heart murmur	☐mitral valve prolapse	☐cancer	☐drug/alcohol dependency

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ 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 breast feeding or pregnant? If pregnant, what is the expected delivery date?
☐ YES ☐NO ☐NOT SURE/MAYBE

Are you answering these questions on behalf of a child or ward? ☐ YES ☐ NO
If YES, does your child or ward clean his/her own teeth? ☐ YES ☐ NO

What has prompted you to visit our office today?_____
When was your last visit to a dental office?_____When was your last dental hygiene visit? _____
How frequently do you visit a dentist office?_____How recently have you had dental x-rays taken? _____
If appropriate, would you like us to request your previous x-rays to be forwarded to our office? ☐ YES ☐ NO ☐ NA

Name of previous dentist: _____
Location: _____
What do you use at home to clean your teeth?
☐ Toothbrush ☐ Rubber tip ☐ Floss
☐ Stimulants ☐ Oral irrigator ☐ Other _____

Do you frequently eat snacks with high sugar content? ☐ YES ☐ NO
Do you have the benefit of fluoride protection such as fluoridated water, toothpaste, tablets, mouthwash or regular professional application? ☐ YES ☐ NO

Temporomandibular Joint

At any time have you had frequent head, neck or shoulder aches?	□ YES	□ NO
Have you ever had difficulty opening or closing your mouth?	□ YES	□ NO
Have you ever had clicking or popping sounds in your jaw joint?	□ YES	□ NO
Do you wake up with soreness in your face or neck muscles?	□ YES	□ NO

Fuctional

Do you favour one side of your mouth when you eat?	□ YES	□ NO
Do you regularly get food or floss caught between your teeth?	□ YES	□ NO
Do you ever have burning sensations in your lips and/or tongue?	□ YES	□ NO
Do you suffer from dryness of the mouth?	□ YES	□ NO
Do you suffer frequently from canker or cold sores?	□ YES	□ NO
Have you ever experienced any injuries to your face or jaw?	□ YES	□ NO
Do any of the following oral habits apply to you?		
Lip biting	□ YES	□ NO
Biting, chewing or holding objects in your mouth	□ YES	□ NO
Mouth breathing	□ YES	□ NO
Clenching when nervous or upset	□ YES	□ NO
Nail biting	□ YES	□ NO
Teeth grinding	□ YES	□ NO
Tongue or soother sucking	□ YES	□ NO
Other (snoring, etc.)_____	□ YES	□ NO

Esthetic

Would you like to know more about:		
Veneers	□ YES	□ NO
Tooth whitening	□ YES	□ NO
Dental implants	□ YES	□ NO
Orthodontics	□ YES	□ NO

Periodontal & Gum Disease

Have you ever had any sore spots in your mouth?	□ YES	□ NO
Do you feel that you have bad breath at times?	□ YES	□ NO
Do your gums ever bleed when brushing, chewing or flossing?	□ YES	□ NO
Have you noticed any movement in your teeth?	□ YES	□ NO

Endodontic & Root Conditions

Are your teeth sensitive to heat or pressure?	□ YES	□ NO
When bending down, do your teeth hurt?	□ YES	□ NO
Have you had a bump or swelling on your gums?	□ YES	□ NO

Previous Dental Care

Have you ever worn an orthodontic appliance?	□ YES	□ NO
Have you ever had treatment for gum disease?	□ YES	□ NO
Have you ever had any of the following dental treatments?		
Filling	□ YES	□ NO
Root canal	□ YES	□ NO
Crown or bridge	□ YES	□ NO
Extraction	□ YES	□ NO
If YES, has a space maintainer ever been recommended?	□ YES	□ NO
Dental or jaw implants	□ YES	□ NO
Cosmetic dentistry	□ YES	□ NO
Do you wear full or partial dentures?	□ YES	□ NO

Consent for Services

The dental and medical profiles I have provided are complete and accurate. I request the dentist, the practice and qualified staff to perform assessment and diagnostic procedures for the purpose of determining my oral health condition and treatment options. As a patient, I understand that I have the right to:

Be advised of the benefits, options and risk of any dental procedure
Ask questions and receive complete answers regarding my oral health
Make an informed decision to accept or decline recommended treatment

I authorize the practice to consult with or transfer my dental records to/from a medical doctor, specialist or another dentist if necessary or requested. I agree that I am financially responsible for all fees incurred during the course of my treatment. I authorize the practice to exchange information with my insurance providers (if any) for the purpose of administering my claims.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to patient:_____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to patient:_____
Signature of guarantor of payment/ Responsible party