Dr. J. Wozney, Dr T. Lee and Associates
347 Main Street. Selkirk, Manitoba. R1A 1T3
Phone: 204 482 5702
Fax: 204 785 8856
reception@redriverdental.ca

PATIENT HISTORY

Name: ______________________________

Name of person responsible for account: ______________________________

Mailing Address: ______________________________

City: ______________________ Province: ______________________

Postal Code: ______________________ Telephone: ______________________

Place of Employment: ______________________ Telephone: ______________________

Dental Insurance Co.: ______________________ Plan Grp/Certificate No.: ______________________

Co-Insurance: ______________________ Birthday: ______________________

E-Mail Address: ______________________ Referred by: ______________________

Reason for visit: ______________________________

Medications: ______________________________

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Please Answer Questions to Medical/Dental History. Answer Yes or No Only	**Yes**	**No**
Are you dissatisfied with the appearance of your teeth?	☐	☐
Are you worried about receiving dental treatment?	☐	☐
Have you ever experienced an unusual reaction to a dental anesthetic?	☐	☐
Do you bleed a long time when you cut yourself?	☐	☐
Have you ever had an injury to your face or jaw?	☐	☐
Have you ever had surgery or x-ray treatment for a tumor, growth or other condition on your mouth or lips?	☐	☐
Are you a mouth breather?	☐	☐
Do you have sensitive teeth?	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐
Have you had a toothache recently?	☐	☐
Do you have frequent canker or cold sores?	☐	☐
Is it difficult for you to open your mouth as wide as you would like?	☐	☐
Are you being treated for any condition by a physician now?	☐	☐
Are you taking any medication now? If Yes – (List Above)	☐	☐
Have you been examined by your physician in the last year?	☐	☐

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Please Answer Questions to Medical/Dental History. Answer Yes or No Only	Yes	No
Have there been any changes in your general health in the last year?	☐	☐
Have you lost weight without dieting in recent months?	☐	☐
Have you ever been seriously ill and hospitalized? If Yes – for what condition?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Have you ever had rheumatic fever, heart operation or hip replacement?	☐	☐
Have you ever had inflammatory rheumatism, hepatitis (what type), HIV positive testing, high blood pressure, tuberculosis, heart attack or stroke?	☐	☐
Have you ever been told by your physician that you have a heart murmur?	☐	☐
Do you have asthma or hay fever?	☐	☐
Are you allergic to anything?	☐	☐
Do you have frequent severe headaches?	☐	☐
Do you have any complaints regarding your eyes?	☐	☐
Do you have trouble with your ears, frequent colds, sinus trouble, nose bleeds or sore throats?	☐	☐
Do you have chest pains on exertion?	☐	☐
Are you short of breath on mild exertion?	☐	☐
Do your ankles swell?	☐	☐
Do you have a persistent cough?	☐	☐
So you have any difficulty in swallowing?	☐	☐
Do you have frequent indigestion?	☐	☐
Do you vomit frequently?	☐	☐
Do you have kidney trouble?	☐	☐
Do you urinate more than six times daily?	☐	☐
Are you thirsty much of the time?	☐	☐
Have you ever had painful swollen joints?	☐	☐
Do you have any blood disorder?	☐	☐
(Women) Is there any chance that you are pregnant at this time?	☐	☐

Name and address of your Physician: ____

Date of review of medical history: **(for office use)** ____________________