

## 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost weight without dieting in recent months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been seriously ill and hospitalized? If Yes – for what condition?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had rheumatic fever, heart operation or hip replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had inflammatory rheumatism, hepatitis (what type), HIV positive testing, high blood pressure, tuberculosis, heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told by your physician that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to anything?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any complaints regarding your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble with your ears, frequent colds, sinus trouble, nose bleeds or sore throats?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pains on exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Are you short of breath on mild exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
So you have any difficulty in swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent indigestion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you vomit frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate more than six times daily?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty much of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had painful swollen joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Is there any chance that you are pregnant at this time?	<input type="checkbox"/>	<input type="checkbox"/>

Name and address of your Physician: \_\_\_\_\_

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