WESTMOUNT DENTAL

# Medical History Questionnaire

**Welcome to our practice. Please provide us the next information:**

First name: _____

Last name: _____

Date of birth (Day/month/year): _____

Home address: _____

_____

Best phone number to reach you: _____

Occupation: _____

How did you hear about us? _____

Name of family doctor: _____

Phone or address family doctor: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship _____

Day-time phone: _____

**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 currently being treated for any medical condition or have you been treated within the past year? If yes, 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? If yes, please explain.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

_____

5. Do you have any allergies? If yes, please list them using the categories below: ☐ Yes ☐ No ☐ Not Sure/Maybe

a) medications _____

b) latex/rubber products _____

c) other (e.g. hay fever, seasonal/environmental, 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

If yes, please explain _____

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 infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/Maybe

_____

12. Have you ever had hepatitis, jaundice or liver disease? ☐ 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 have or have you ever had any of the following? Please check.

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

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ 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. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

☐ Yes ☐ No ☐ Not Sure/Maybe

21. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

**To the best of my knowledge, the above information is correct:**

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST'S NOTES: