MEDICAL DENTAL HISTORY QUESTIONNAIRE

1. Patient Information

First Name:_____ Last Name:_____ DOB:_____/_____/_____
D M Y

Address:_____ City:_____ Province:_____ Postal Code:_____

Home phone:_____ Business: _____ Cell: _____ Email address: _____

Would you like to be an annual patient? N / Y How did you hear about the SAIT Dental Clinic?

Physician: _____ Phone Number: _____ Dentist: _____ Phone Number: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number:_____

The following information is required to help us provide you with the best possible dental care. The student and supervising dental health care professional will review and explain any questions you may not understand. All information is confidential and is treated in accordance with applicable privacy legislation.

2. Dental Health

1. When was your last dental check-up at a general dental office?	2. When were your last dental x-rays taken?
2. When was your last dental cleaning?	4. How often do you brush your teeth? Floss?

Please check Yes or No for the following:	Yes	No		Yes	No
5. Do your gums bleed?			10. Have you ever had a head and/or neck injury?		
6. Do you have any dental concerns at this time?			11. Do you suffer from frequent headaches?		
7. Have you ever had orthodontic treatment/braces?			12. Do you have a removable dental appliance?		
8. Are your teeth sensitive to touch, temperature, or sweets?			13. Do you have dental implants?		
9. Have you ever had periodontal (gum) surgery or treatment?			14. Do you have a dry mouth?		

Please explain in detail all “Yes” answers.

3. Health History

1. When was your last medical visit? Reason:

Please check Yes or No for the following:	Yes	No		Yes	No
2. Have you had any changes to your health or any treatment for medical concerns in the past year?			5. Have you ever had an adverse reaction to any medications or injections?		
3. Have you ever been hospitalized for any illness or operation?			6. Do you have any allergies?		
4. Have you ever been advised to take antibiotics before dental treatment?			7. WOMEN: Are you pregnant or breastfeeding?		

Please explain in detail all “Yes” answers.

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4. Are you taking any medications, including prescription, over the counter, and natural health products? Please list		
DRUG NAME	AMOUNT, DOSE, FREQUENCY	REASON

Do you have or have had any of the following:

5. **Cardiovascular/Respiratory**	Yes	No	**7. Immune System/Infectious Diseases**	Yes	No
Angina			HIV/AIDS		
Heart valve problems			Systemic lupus erythematosus		
Congenital heart defects			Other conditions that affect the immune system (steroid therapy, Epstein bar, chemotherapy/radiation, cancer)		
Artificial heart valves/valvular conditions					
Heart disease			Sexually transmitted infections (e.g. herpes)		
Chest pain			**8. Endocrine/Digestion**		
Heart attack			Diabetes, what type?		
Heart murmur			Thyroid/Parathyroid disease		
Blood pressure problems			Eating disorder		
Congestive heart failure			Dietary restrictions		
Heart surgery/Transplant			**9. Gastrointestinal/Urinary**		
Pacemaker			Hepatitis/Jaundice/Liver Disease		
Infective Endocarditis			Acid reflux/Heart burn		
Shortness of breath			Stomach ulcers		
Swollen ankles			Kidney disease		
Asthma			**10. Neurological/Muscular/ Skeletal**		
Tuberculosis			Stroke		
Sinus problems			Seizure disorder/Epilepsy		
Chronic cough/new cough			Mental health disorder		
Emphysema/Chronic bronchitis			Arthritis/Rheumatoid arthritis		
			Osteoporosis		
6. Haematological(Blood)			Joint replacement		
Blood Transfusion			**11. Other**		
Abnormal bruising			Do you use any type of tobacco products?		
Abnormal bleeding			Do you have a drug/alcohol dependency?		
Blood disorder			Do you have any vision or eye problems?		
			Have you had any recent changes to your weight?		

Please explain in detail all “Yes” answers and any other medical condition we should be aware of.

By signing below, I agree that all of the above information is correct to the best of my knowledge.

Patient/Parent/Guardian Signature:_____ Date:_____

SAIT Dental Assisting Student Signature:_____ Date: _____

SAIT Faculty Signature (DDS/RDH): _____ Date: _____

Respirations:	Blood Pressure:	Pulse Rate:

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