MEDICAL HISTORY QUESTIONNAIRE

Medical Alert:

____
Name

____
Date of Birth (D/M/Y)

____
Phone (Home) (Cell)

____
Address

____

____
Nova Scotia Health Card Number Expiry Date

____
Insurance

____
Policy Holder

____
Company

____
Policy No.

____
Address (Business)

____
Phone (Business)

____
Occupation

____
Who referred you to our office?

In Case of Emergency, We Should Notify:

____
Name

____
Relationship

____
Day-Time Phone Number

____
Name of Family Doctor

____
Phone or Address

The following information is required to enable us to provide you with the best 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 at present or have you been treated within the past year? If yes, please explain.
   ____

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.
   ____
   ____

NSDA
Nova Scotia Dental Association

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
____
____
____

5. Do you have any allergies?
❐Medications ❐Foods ❐Latex/Rubber Products ❐Nickel ❐Silver ❐Other Metals
____
____

6. Have you ever had an adverse reaction to any medications or injections?
____

7. Do you have or have you ever had asthma?
____

8. Do you have or have you ever had any heart or blood pressure problems?
____

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? If yes, explain.
____
____

10. Do you have a prosthetic or artificial joint? If yes, explain.
____

11. Do you have any conditions or are undergoing any therapies that could affect your immune system (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? If yes, explain.
____

12. Have you ever had hepatitis, jaundice or liver disease? If yes, explain.
____

13. Do you have a bleeding problem or bleeding disorder? If yes, explain.
____

14. Have you ever been hospitalized for any illness or operations? If yes, explain.
____

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15. Do you have, or have you ever had any of the following? If yes, please check.

❒Chest pain/angina	❒Rheumatic fever	❒Pacemaker	❒Steroid therapy
❒Osteoporosis medications	❒Seizures (epilepsy)	❒Heart attack	❒Mitral valve prolapse
❒Lung disease	❒Diabetes	❒Kidney disease	❒Stroke
❒Heart murmur	❒Tuberculosis	❒Stomach ulcers	❒Thyroid disease
❒Shortness of breath	❒Cancer	❒Arthritis	❒Drug/alcohol dependency
❒Sleep apnea	❒Acid reflux	❒Eating disorder (bulimia/anorexia)	

16. Are there any conditions or diseases not listed above that you have, or have had? If so, what?
____
____

17. Are there any disease or medical problems that run in your family? If yes, explain.
____
____

18. Do you use any tobacco or cannabis products? If so, what specific type and frequency of use?
____

19. Do you drink alcohol? If so, how much do you drink each week?
____

20. Do you use any controlled or “recreational” drugs such as cocaine, ecstasy, LSD, heroin? If so, please identify.____

21. Are you nervous during dental treatment? __________________________________

22. <u>For women only:</u> Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? ____

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

________________________________ ________________________________
Patient/Parent/Guardian Signature **Date**

________________________________ ________________________________
Dentist Signature **Date**