Port Credit Dental

HEALTH INFORMATION

1) Are you being treated for any medical conditions at present or within the past two years?
   If yes, please explain: _____
   Physician: _____
   Phone Number: _____
2) Have you been hospitalized in the past two years? ◯ Yes ◯ No
3) When was your last complete physical examination?
   _____
4) Have you had or do you have any of the following? Check all that apply.

☐ A.I.D.S / HIV+	☐ Epilepsy or seizures	☐ Hodgkin's	☐ Mitral valve prolapsed
☐ Anemia	☐ Excessive Bleeding	☐ Disease	Mumps
☐ Angina Pectoris	☐ Fainting or dizzy	☐ Hyper(Hypo)	☐ Rheumatic/Scarlet fever
☐ Arthritis/rheumatism	spells	☐ Glycemia	☐ Sickle Cell Disease
☐ Artificial heart valve	☐ Glandular disorders	☐ Inflammatory	☐ Sexually Transmitted
☐ Artificial joints	☐ Glaucoma	☐ Bowel Disease	Infections
☐ Asthma	☐ Hay Fever	☐ Jaundice	☐ Sinus trouble
☐ Blood disorders	☐ Head/ neck injury	☐ Kidney Disease	☐ Sleep apnea
☐ Bronchitis	☐ Heart Disease or	☐ Liver Disease	Use of CPAP? **Y N**
☐ Cancer	attack	☐ Low blood	☐ Stomach/intestinal
☐ Chemotherapy	☐ Heart Murmur	pressure	problems/Ulcers
☐ Chicken pox	☐ Heart pacemaker	☐ Lung Disease	☐ Strep throat
☐ Circulation problems	☐ Heart surgery	☐ Lupus	☐ Stroke
☐ Congenital heart	☐ Hepatitis A B C	☐ Malignant	☐ Tonsillitis
lesions	☐ Herpes	☐ Hyperthermia	☐ Thyroid disease
☐ Crohn's Disease	☐ High blood	☐ Measles	☐ Tuberculosis
Diabetes	pressure	☐ Mental/nervous	OTHER:_____
☐ Emphysema		disorder	_____
			_____

5) Have you recently, or are you presently taking PRESCRIPTION or NON-PRESCRIPTION drugs including herbal remedies?
   If yes, please list or provide your medications list to the front desk to make a copy.
   1._____2. _____3. _____ 4._____
   5._____ 6._____ 7._____ 8. _____
6) Have you ever reacted adversely to any medications or injections?
   If yes, please circle: Penicillin (or other antibiotics), Aspirin, Codeine, Local Anesthetic (Freezing), Nitrous Oxide, or any other medicine please indicate:
   _____
7) Have you been advised against taking any specific medication? ☐ Yes ☐ No
8) Do you have any allergies? If yes, please circle and explain below: Food, metal, LATEX
   Allergy details: _____
9) Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction?
   If yes, please explain:_____
10) Is there a family history of Diabetes, Cancer or Heart Disease? ☐ Yes ☐ No
11) Do you bleed excessively from a cut or injury, or bruise easily? ☐ Yes ☐ No
12) Do you have frequent severe headaches, earaches, ear/throat infection? ☐ Yes ☐ No
13) Have you ever had an injury or surgery to your face or jaws? ☐ Yes ☐ No
14) Do you have any hearing difficulties? ☐ Yes ☐ No
15) Do you smoke or use any other forms of tobacco or the transdermal nicotine patch? ☐ Yes ☐ No
16) Are you alcohol and/or drug dependent? If yes, have you received treatment? _____
17) Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, what month? ____ Are you breast feeding? _____

Port Credit Dental

DENTAL HISTORY

1) Is there a dental problem you would like treated immediately? _____
2) When was the last time you saw a dentist? _____
3) What was that appointment for? _____
4) Have you been seeing a dentist regularly? ☐ Yes ☐ No
5) Have you ever had any of the following? Check all that apply:

☐ Periodontal treatment (treatment of gums) ☐ Orthodontic treatment (realignment of teeth) ☐ Appliances such as a night guard, denture, bridge, etc.	☐ Your bite adjusted or teeth ground ☐ Dental anxiety ☐ Oral surgery (ex. jaw surgery or implant surgery)

6) Are there any growths or sore spots in your mouth? ☐ Yes ☐ No
7) Do your gums bleed when brushing or eating? ☐ Yes ☐ No
8) Do you suffer from pain or swelling of your gums? ☐ Yes ☐ No
9) Have you noticed any loose teeth, or have any of your teeth shifted? ☐ Yes ☐ No
10) Does food catch between your teeth? ☐ Yes ☐ No
11) Are any of your teeth sensitive to heat, cold, sweets or pressure? ☐ Yes ☐ No
12) Have you been advised to take antibiotics before a dental appointment? ☐ Yes ☐ No
13) Do you use dental floss, proxabrush or stimudents? How often? ☐ Yes ☐ No
14) Do you feel that you have bad breath? ☐ Yes ☐ No
15) How often do you brush your teeth? _____
16) Have you ever experienced any of the following jaw problems? Check all that apply:

☐ Popping/clicking in your jaw joints
☐ Pain in your jaw joints, around your ear, or side of your face
☐ Difficulty in opening or closing
☐ Pain when teeth are clenched
☐ Pain or difficulty while chewing

17) Do you have any of the following habits? Check all that apply:

☐ Clenching or grinding your teeth while awake or asleep
☐ Biting your cheeks or lips
☐ Mouth breathing while awake or asleep
☐ Placing foreign objects in your mouth (pencils, fingernails, etc)?

18) Do you have any emotional concerns about having dental treatment? ☐ Yes ☐ No
19) Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
If so, what would you like to see changed?
_____
_____
20) Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?
_____
_____