HUMBERLAND DENTAL

MEDICAL HISTORY

Patient Name_____ Preferred Name_____ Current Age_____

Name of Family Doctor_____
Date of last physical examination_____
What is your estimate of your general health? Poor ☐ Fair ☐ Good ☐

Have you ever had the following:

	YES	NO
1 hospitalization for illness or injury.....	☐	☐
2 **allergic reaction to:**		
☐aspirin ☐local anesthetic		
☐penicillin ☐fluoride		
☐erythromycin ☐metals (gold, stainless steel)		
☐codeine		
☐any other medications _____		
3 heart problems.....	☐	☐
4 heart murmur.....	☐	☐
5 rheumatic fever.....	☐	☐
6 scarlet fever.....	☐	☐
7 high blood pressure.....	☐	☐
8 low blood pressure.....	☐	☐
9 stroke.....	☐	☐
10 artificial prosthesis (ex: heart valve or joints)	☐	☐
11 anemia or other blood disorders.....	☐	☐
12 prolonged bleeding due to a slight cut...	☐	☐
13 emphysema.....	☐	☐
14 tuberculosis.....	☐	☐
15 asthma.....	☐	☐
16 sinus problems.....	☐	☐
17 kidney disease.....	☐	☐
18 liver disease.....	☐	☐
19 jaundice.....	☐	☐
20 thyroid or parathyroid disease.....	☐	☐
21 hormone deficiency.....	☐	☐
22 high cholesterol.....	☐	☐
23 diabetes.....	☐	☐
24 stomach or duodenal ulcer.....	☐	☐

	YES	NO
25 digestive disorders.....	☐	☐
26 arthritis.....	☐	☐
27 glaucoma.....	☐	☐
28 contact lenses.....	☐	☐
29 head or neck injuries.....	☐	☐
30 epilepsy, convulsions (seizures).....	☐	☐
31 viral infections or cold sores.....	☐	☐
32 any lumps or swelling in the mouth.....	☐	☐
33 hives, skin rash, hay fever.....	☐	☐
34 venereal disease.....	☐	☐
35 hepatitis (type___).....	☐	☐
36 HIV/AIDS.....	☐	☐
37 tumor, abnormal growth.....	☐	☐
38 radiation therapy.....	☐	☐
39 chemotherapy.....	☐	☐
40 emotional problems.....	☐	☐
41 psychiatric treatment.....	☐	☐
42 antidepressant medication.....	☐	☐
43 alcohol/drug dependency.....	☐	☐
44 osteoporosis.....	☐	☐
Are you:		
45 presently being treated for any illness.....	☐	☐
46 aware of a change in your general health..	☐	☐
47 often exhausted or fatigued.....	☐	☐
48 subject of frequent headaches.....	☐	☐
49 a smoker.....	☐	☐
50 FEMALE - taking birth control pills.....	☐	☐
51 FEMALE - pregnant.....	☐	☐
52 MALE - prostate disorder.....	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications taken_____

PLEASE COMPLETE REVERSE SIDE **

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY ALONG WITH ANY NEW MEDICATIONS

Patient's Signature_____ I understand that completing this field acts as the equivalent to my valid physical signature **Date**_____

Doctor's Signature_____ Date_____

HUMBERLAND DENTAL

DENTAL HISTORY

Referred by _____

Previous dentist_____

Last dental exam _____ Last dental x-ray_____ Last dental treatment_____

How often do you have your teeth cleaned? 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 1 year or longer ☐

Please answer YES or NO to the following questions:

		YES	NO
1	unhappy with the appearance of your teeth	☐	☐
2	unfavourable dental experiences	☐	☐
3	dental fears	☐	☐
4	problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5	orthodontic treatment (braces), IF YES when_____	☐	☐
6	periodontal (gum) treatment, IF YES when_____	☐	☐
7	bleeding gums	☐	☐
8	avoid brushing any part of your mouth	☐	☐
9	part of your mouth is sensitive to temperature	☐	☐
10	sore teeth	☐	☐
11	a burning sensation in your mouth	☐	☐
12	difficulty swallowing	☐	☐
13	an unpleasant taste or odour in your mouth	☐	☐
14	dry mouth	☐	☐
15	jaw problems (temporomandibular joint)	☐	☐
16	difficulty opening your mouth widely	☐	☐
17	stiff neck muscles	☐	☐
18	awaken with an awareness of your teeth or jaws	☐	☐
19	tension headaches	☐	☐
20	clench or grind your teeth	☐	☐
21	jaw clicking or popping	☐	☐
22	lost any teeth	☐	☐

If you are wearing a partial or complete artificial denture, please complete the following:

SUPPLEMENTAL DENTURE HISTORY:

YES	NO	Please check YES or NO
☐	☐	Has your present denture been relined? When _____
☐	☐	Is your present denture a problem? Describe_____
☐	☐	Are you satisfied with appearance?_____
☐	☐	Are you satisfied with comfort?_____
☐	☐	Are you satisfied with chewing ability?_____
		When did you receive your first partial or complete denture?_____
		How long have you worn your present denture?_____

Patient's Signature_____ I understand that completing this field acts as the equivalent to my valid physical signature **Date**_____

Doctor's Remarks_____

Doctor's Signature_____ Date_____