MEDICAL AND DENTAL QUESTIONNAIRE

PERSONAL INFORMATION

Name _____ Date _____
mo. day yr.

Mailing Address _____ Postal Code _____ Date of Birth _____ _____ _____

Telephone: Home _____ Cell: _____ Business _____

Person responsible for account: self, insurance, welfare, other _____ Martial Status _____

Dental Insurance — YES NO Dual Coverage — YES NO Email _____

Insurance Company _____

Employer _____ Occupation _____

Personal Physician _____ Telephone _____

Whom may we thank for referring you? _____ Previous Dentist _____

In case of emergency notify: Name _____ Telephone _____

Relationship _____

MEDICAL HISTORY

CIRCLE

1. Have you ever been hospitalized and was surgery performed? ..... YES NO
   Please specify _____
2. Is your physician treating you now? ..... YES NO
   Please specify _____
3. Have you heart disease or murmur? ..... YES NO
4. Are your ankles often swollen? ..... YES NO
5. Have you had rheumatic fever? ..... YES NO
6. Are your activities limited? ..... YES NO
7. Do you become breathless easily? ..... YES NO
8. Have you had abnormal bleeding? ..... YES NO
9. Have you gained or lost excessive weight recently? ..... YES NO
10. Have you ever had radiation or X-ray therapy? ..... YES NO
11. Have you taken cortisone or steroids? ..... YES NO
12. Have you any allergies? ..... YES NO
13. Have you had an allergic reaction to any drugs or medicines e.g. penicillin? ..... YES NO
    Please specify _____
14. Are you taking any prescription or non-prescription drugs or medicines? ..... YES NO
    Please specify _____
15. Do you have or have you had? Circle ..... YES NO

Heart trouble	Epilepsy	Blood Disorders
High Blood Pressure	Thyroid trouble	Diabetes
Kidney trouble	Tuberculosis	Anaemia
Liver trouble (e.g. jaundice, hepatitis)	Asthma	Any others - Specify _____
A.I.D.S	Venereal diseases (syphilis, gonorrhea)	_____

16. Are you on a special diet? ..... YES NO
17. Are you currently in good health? ..... YES NO
18. Is there anything else you think you should tell me? ..... YES NO
    Please Specify _____

FOR WOMEN ONLY

19. Are you pregnant? If so, what month? _____ YES NO

DENTAL HISTORY

		CIRCLE	
1.	Have you been under regular care by a dentist?	NO	YES
2.	Have you ever had local anaesthetic (freezing)?	NO	YES
3.	Were there any complications?	NO	YES
	Specify _____		
4.	Have you ever had any teeth extracted?	NO	YES
5.	Were there any complications involved afterwards?	NO	YES
6.	Do any of your teeth ache?	NO	YES
7.	Do your gums bleed when you brush?	NO	YES
8.	Do your gums feel tender or swollen?	NO	YES
9.	Do you have any loose teeth?	NO	YES
10.	Does food catch between your teeth?	NO	YES
11.	Are you dissatisfied with the appearance of you teeth?	NO	YES
12.	Have you every had problems with you jaw joint or facial muscles (e.q. grating, popping, clicking)?	NO	YES
13.	Have you had an injury to your face or jaws?	NO	YES
14.	Have you noticed your bite changing?	NO	YES
15.	Have you difficulty opening your mouth?	NO	YES
16.	Do you have headaches?	NO	YES
17.	Are you nervous about going to the dentist?	NO	YES

18. Describe in you own words, your present dental problem

_____

_____

_____

PERMIT FOR OPERATIONS

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____

QUESTIONNAIRE UPDATE

Please check over and update information, with a different coloured pen, to ensure that all information is correct and sign below.

1. Date _____ Signature _____

2. Date _____ Signature _____

3. Date _____ Signature _____

4. Date _____ Signature _____

5. Date _____ Signature _____

6. Date _____ Signature _____