MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

_____

DATE OF BIRTH (DAY/MONTH/YEAR):____/____/_____

ADDRESS (HOME):

_____

_____

CELL:_____HOME_____

EMAIL:_____

ADDRESS (BUSINESS):

_____

_____

OCCUPATION : _____

WHO REFERRED YOU TO OUR OFFICE?

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME_____

RELATIONSHIP_____

DAY-TIME PHONE_____

NAME OF FAMILY DOCTOR_____

PHONE OR EMAIL ADDRESS_____

_____

_____

(1) NAME OF MEDICAL SPECIALIST_____

AREA OF SPECIALITY_____

PHONE OR ADDRESS_____

(2) NAME OF MEDICAL SPECIALIST_____

AREA OF SPECIALITY_____

PHONE OR ADDRESS_____

The following information is required to enable us to provide you with the best possible 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 the present or have you been treated within the past year?
   If so, why ? ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   _____

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.
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   _____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   _____

5. Do you have any allergies? If you answered yes, please list using the categories below:
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

   a) medications
   b) latex/rubber products
   c) other (e.g. hayfever, foods)
   _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   _____

7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ osteoporosis medications (e.g. Fosamax, Actonel)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke		☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
☐ shortness of breath	☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol dependency	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products ? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Are you nervous during dental treatment ? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____

DENTIST'S NOTES

diptiDental: The Practice of Dr. Anisa Shaikh
Suite 413, 73 Richmond Street West, Toronto, ON M5H4E8 CANADA O: 647.430.7309 E: smile@diptiDental.com
www.diptiDental.com

diptiDental

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PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____Date of Birth: _____ Sex: _____ Age: _____

Home Address:_____ City: _____ State: _____ Zip: _____

Billing Address (If Different): _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Driver's License #: _____ State: _____

SS #: _____Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency Phone #: _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber' name: _____ Date of birth: _____ SS #:_____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problem with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do you gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with :		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaw ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you habitual gum chewer or pipe smoker ?	☐	☐

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