



HAYDEN CHARLES DENTAL CARE

MEDICAL HISTORY QUESTIONNAIRE

Name : _____

Date of Birth (DD/MM/YYYY) : _____

Address : _____

Phone : _____

Email ID : _____

Occupation : _____

Referred by : _____

In case of Emergency, we should notify :

Emergency Contact Name : _____

Relationship : _____

Phone : _____

Name of Family Doctor : _____

Phone or Address : _____

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 anything that you do not understand. Please fill in the entire form.

1) Are you currently being treated for any medical condition or have you been treated within the past year?

Yes No Not Sure/Maybe

If yes, please explain : _____

2) When was your last medical check-up? _____

3) Has there been any change in your general health in the past year?

Yes No Not Sure/Maybe

If yes, please explain : _____

4) Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

Yes No Not Sure/Maybe

If yes, please list them : _____

5) Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

Yes No Not Sure/Maybe

If yes, please list them : _____

6) Do you have any allergies?



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Yes No Not Sure/Maybe

If yes, please list them using the categories below :

- Medications _____
- Latex/Rubber products _____
- Other (eg. Hay fever, seasonal/environmental, foods) _____

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? Yes No Not Sure/Maybe

If yes, please explain : _____

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

- | | | | | |
|---------------------------------------------|---------------------------------------------------------------------|---------------------------------------|------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Chest pain, Angina | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke, TIA | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Drug/Alcohol/Cannabis
Use or dependency | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis Medications
(eg., Fosamax, Actonel) |

16) Are there any conditions or diseases not listed above that you have or have had?

Yes No Not Sure/Maybe

If yes, please explain : _____

17) Are there any diseases or medical problems that run in your family? (e.g., diabetes, cancer or heart disease)

18) Do you Smoke or chew tobacco products?

Yes No Not Sure/Maybe



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Yes No Not Sure/Maybe

19) Are you nervous during dental treatments?

Yes No Not Sure/Maybe

20) Are you breast feeding or pregnant? If pregnant, what is the expected delivery date?

Yes No Not Sure/Maybe

21) Do you identify as a patient with a disability?

Yes No Not Sure/Maybe

If yes, please explain : _____

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

Patient/Parent/Guardian Signature : _____ Date : _____

Dentist Signature : _____ Date : _____

DENTIST'S NOTES :