MEDICAL HISTORY QUESTIONNAIRE

All information provided is confidential

Happy Smiles Dental Hygiene

NAME: Mr./Miss/Mrs./Ms./Dr.

IN CASE OF EMERGENCY, WE SHOULD NOTIFY-
NAME:

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

RELATIONSHIP:

DAY-TIME PHONE:

ADDRESS (HOME):

POSTAL CODE

NAME OF FAMILY DOCTOR:

PHONE:

CELL:

PHONE OR ADDRESS OF FAMILY DOCTOR:

EMAIL ADDRESS:

WHERE DID YOU HEAR ABOUT ME :

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
2.	Are you taking any medications, non-prescription drugs of any kind? If yes, please list.	☐ YES	☐ NO
3.	Do you have any allergies? If you answered yes, please list using the categories below: a) medications b) latex/rubber gloves c) other (e.g. hay fever, foods)	☐ YES	☐ NO
4.	Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.	☐ YES	☐ NO
5.	Do you or have you ever had asthma?	☐ YES	☐ NO
6.	Do you have or have you ever had any heart or blood pressure problems?	☐ YES	☐ NO
7.	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 condiction from birth (i.e. congenital heart disease) or a heart transplant?	☐ YES	☐ NO
8.	Do you have a prosthetic or artificial joint?	☐ YES	☐ NO
9.	Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?	☐ YES	☐ NO
10.	Have you ever had hepatitis, jaundice or liver disease?	☐ YES	☐ NO
11.	Do you have a bleeding problem or bleeding disorder?	☐ YES	☐ NO
12.	Have you ever been hospitalized for any illnesses or operations? If yes, please explain.	☐ YES	☐ NO

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

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ cancer
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease	☐ drug/alcohol dependency
☐ stroke	☐ heart murmur	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	

14.	Do you smoke or chew tobacco products?	☐ YES	☐ NO
15.	Are you nervous during dental treatments?	☐ YES	☐ NO
16.	**For women only:** Are you breastfeeding or pregnant? If pregnant, what is the the expected delivery date?	☐ YES	☐ NO

To the best of my knowledge, the above information is correct: I consent to the recommended Dental Hygiene treatment required

PATIENT/GUARDIAN SIGNATURE

DATE