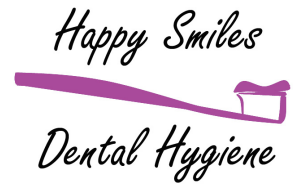


# MEDICAL HISTORY QUESTIONNAIRE

All information provided is confidential



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

DATE OF BIRTH (DAY/MONTH/YEAR):

/ /

ADDRESS (HOME):

POSTAL CODE

PHONE:

CELL:

EMAIL ADDRESS:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY-

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS OF FAMILY DOCTOR:

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:  YES  NO
  - a) medications
  - b) latex/rubber gloves
  - c) other (e.g. hay fever, foods)
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 condition 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.

- |   |  |                                       |  |  |  |
|---|--|---------------------------------------|--|--|--|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> shortness of breath   | <input type="checkbox"/> pacemaker    | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> cancer                  |
| <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"/> drug/alcohol dependency |
| <input type="checkbox"/> stroke             | <input type="checkbox"/> heart murmur          | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers  | <input type="checkbox"/> 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