DENTAL WORKS
ON CORNWALL

Medical and Dental History

MEDICAL ALERT

Name: MR./MISS/MRS./MS./DR. ____________________

Date of Birth (DAY/MONTH/YEAR): ____________________

Address (Home): ____________________

____

Email: ____________________

Phone (home): ____________________ Phone (work): ____________________

How did you find out about our office? ____________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: ____________________ Relationship: ____________________

Phone (daytime): ____________________

Name of Family Doctor: ____________________ Phone or Address: ____________________

(1) Name of Medical Specialist: ____________________

Area of Specialty: ____________________ Phone or Address: ____________________

(2) Name of Medical Specialist: ____________________

Area of Specialty: ____________________ Phone or Address: ____________________

DENTAL HISTORY:

- Are you unhappy with your teeth and their appearance? ❑ YES ❑ NO
- Do you think that you have active decay or gum disease? ❑ YES ❑ NO
- Do you feel nervous about dental treatment? ❑ YES ❑ NO
- Is there something specific about dental treatment that makes you nervous?
  If so, what? (anaesthetic? Sound of the drill?) ____________________
- Have you ever had a negative experience in the dental office? ❑ YES ❑ NO
- Does food catch between your teeth? ❑ YES ❑ NO

DENTAL WORKS
ON CORNWALL

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.

MEDICAL HISTORY:

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

❑ YES ❑ NO ❑ NOT SURE/MAYBE

If so, why? ______________________________

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: ______________________________

5) Do you have any allergies? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If you answered yes, please list using the categories below:

Medications: ______________________________ Latex/Rubber products: ______________________________

Other (hayfever, foods) ______________________________

6) Have you ever had a peculiar or adverse reaction to any medicines or injections?

❑ YES ❑ NO ❑ NOT SURE/MAYBE

If yes, please explain: ______________________________

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

DENTAL WORKS
ON CORNWALL

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.

❑ Chest pain, angina	❑ Rheumatic fever	❑ Tuberculosis	❑ Arthritis
❑ Heart attack	❑ Mitral valve prolapse	❑ Cancer	❑ Seizures (epilepsy)
❑ Stroke	❑ Heart murmur	❑ Steroid therapy	❑ Kidney disease
❑ Shortness of breath	❑ Pacemaker	❑ Diabetes	❑ Thyroid disease
❑ Osteoporosis	❑ Lung disease	❑ Stomach ulcers	❑ Drug/alcohol dependency

16) Are there any conditions or diseases not listed above that you have or have had? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If so, what: ______________________________

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? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If pregnant, what is the expected delivery date? ______________________________

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

PATIENT/PARENT/GUARDIAN

Signature: ______________________________ **Date:** ____________________

DENTIST

Signature: ______________________________ **Date:** ____________________

DENTAL WORKS
ON CORNWALL

Smile Evaluation

- Are you dissatisfied with the appearance of your smile? ❑ YES ❑ NO
- Do you have spaces or gaps between your teeth? ❑ YES ❑ NO
- Do you have old fillings or dental work that you don't like looking at? ❑ YES ❑ NO
- Are your teeth… (please circle any of the following that apply)

chipped protruding crowded misshapen

- If you could change one thing about your smile, what would it be?

____

____

____

- If we could offer a simple and inexpensive way to whiten your teeth, would you be interested? ❑ YES ❑ NO
- How would you like your teeth to look in 15 years?

____

____

____