VIANA FAMILY DENTAL CENTRE

Your Health & Comfort is Our Happiness

# ADULT MEDICAL HISTORY QUESTIONAIRE

Date: _____

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

_____

DATE OF BIRTH (DD/MM/YY): _____/_____/_____

ADDRESS (HOME):

Street_____

Apt/Unit_____City_____

Prov._____Postal Code_____

CELL: _____

HOME PHONE: _____

OCCUPATION: _____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

EMAIL: _____ ____

NAME OF FAMILY DR.:_____

DR'S NUMBER: _____

**IN CASE OF EMERGENCY, WE SHOULD NOTIFY:**

NAME: _____

RELATIONSHIP: _____

PHONE: _____

**INSURANCE INFORMATION**

INSURED'S NAME: _____

DATE OF BIRTH (DD/MM/YY) _____/_____/_____

INSURED'S EMPLOYER: _____

INSURANCE COMPANY: _____

POLICY#_____

CERTIFICATE#_____

ACCOUNT HOLDER: _____

DO YOU HAVE ADDITIONAL INSURANCE COVERAGE?

_____

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.
Thank you.

1. Are you being treated for any medical condition at the present or have you been treated within the past 3 years?
   If so, why? _____ ○ YES ○ NO ○ NOT SURE/MAYBE
2. When was your last medical check-up?
   _____
3. Have there been any changes 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

○ a) Medications
○ b) latex/rubber products
○ c) Other (i.e. hay fever, foods)

1. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

_____ ○ YES ○ NO ○ NOT SURE/MAYBE

2. Do you have or have you ever had asthma? ○ YES ○ NO
3. Do you have or have you ever had any heart or blood pressure problems? ○ YES ○ NO
4. 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
5. Do you have a prosthetic or artificial joint? ○ YES ○ NO
6. Do you have any conditions or therapies that could affect your immune system, E.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ○ YES ○ NO
7. Have you ever had hepatitis, jaundice or liver disease? ○ YES ○ NO
8. Do you have a bleed problem or bleeding disorder? ○ YES ○ NO
9. Have you ever been hospitalized for any illness or operations? If yes please explain. YES ○ ○ NO

   _____

10. Do you have or have you ever had any of the following? Please Check.

| | | | | |
|---|---|---|---|---|
| ☐ Chest pain, angina | ☐ Rheumatic fever | ☐ Pacemaker | ☐ Steroid therapy | ☐ Tuberculosis |
| ☐ Osteoporosis Medication | ☐ Heart attack | ☐ Mitral valve prolapse | ☐ Lung disease | ☐ Stomach ulcers |
| ☐ Kidney Disease | ☐ Stroke | ☐ Heart murmur | ☐ Seizures (epilepsy) | ☐ Arthritis |
| ☐ Thyroid disease | ☐ Shortness of breath | ☐ Cancer | ☐ Diabetes | |
| ☐ Drug/Alcohol Dependency | ☐ Other_____ | | | |

11. Are there any diseases or medical problems that run in your family?

    _____ ○ YES ○ NO ○ NOT SURE

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

    _____ ○ YES ○ NO

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

PATIENT/PARENT/GARDIAN SIGNATURE:

_____DATE:_____

DENTIST SIGNATURE:

_____DATE:_____

DENTIST'S NOTES: