Lafleur FAMILY DENTISTRY

Patient Medical and Dental Questionnaire

General Information

NAME: _____ TODAY'S DATE: _____

MAILING ADDRESS: _____

CITY/TOWN: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____ EXT. _____

EMAIL: _____ MARITAL STATUS: _____

DATE OF BIRTH: D _____ M _____ Y _____ GENDER: _____ AHC#: _____

FAMILY PHYSICIAN: _____ PHONE: _____

INSURANCE INFO: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

Medical History

1. HAVE YOU BEEN HOSPITALIZED OR HAD SURGERY IN THE LAST 2 YEARS?
   ☐ YES ☐ NO IF YES PLEASE SPECIFY: _____
2. DO YOU HAVE ANY ALLERGIES? (EG. LATEX, PENICILLIN, ANAESTHETIC, FOOD, ETC.)
   ☐ YES ☐ NO IF YES PLEASE SPECIFY: _____
3. HAVE YOU BEEN ADVISED BY A MEDICAL DOCTOR OR DENTIST TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?
   ☐ YES ☐ NO IF YES PLEASE SPECIFY: _____

4. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (PRESCRIPTIONS, VITAMINS, ASPIRIN)

☐ YES ☐ NO IF YES PLEASE SPECIFY: _____

5. DO YOU USE ALCOHOL/TOBACCO/CANNABIS/RECREATIONAL DRUGS?

☐ YES ☐ NO IF YES HOW MUCH/OFTEN: _____

6. DO YOU EXPERIENCE SHORTNESS OF BREATH OR CHEST PAIN? ☐ YES ☐ NO

7. ARE YOUR ACTIVITIES LIMITED? ☐ YES ☐ NO

8. DO YOU HAVE ABNORMAL BLEEDING? ☐ YES ☐ NO

9. WHEN WAS YOUR LAST DENTAL VISIT? _____

NAME OF PREVIOUS DENTIST: _____

10. DO YOU OFTEN HAVE FREQUENT AND/OR SEVERE HEADACHES, EARACHES, EAR/THROAT/SINUS INFECTIONS? ☐ YES ☐ NO

11. DO YOU HAVE ANY ARTIFICIAL JOINTS? ☐ YES ☐ NO

IF YES, WHERE? _____ DATE OF PLACEMENT: _____

12. PLEASE CHECK THE FOLLOWING YOU PRESENTLY OR HAVE EVER HAD:

☐ ACID REFLUX
☐ ADHD
☐ ANXIETY
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE
☐ ASTHMA
☐ AUTOIMMUNE
☐ DISORDER
☐ BLOOD TRANSFUSION
☐ BLOOD DISORDERS
☐ CANCER
☐ HIGH CHOLESTEROL
☐ CHEMOTHERAPY or RADIATION
☐ CIRCULATION
☐ CHRONES/COLITIS
☐ COLD SORES
☐ CONGENTIAL HEART LESIONS

DIABETES:
☐ TYPE 1 ☐ TYPE 2
☐ EATING DISORDERS
☐ EMPHYSEMA
☐ EPILEPSY/SEIZURES
☐ FAINTING/DIZZY
☐ GLAUCOMA
☐ HEART DISEASE
☐ HEART ATTACK
☐ HEART SURGERY

HEPATITIS
☐ A ☐ B ☐ C
☐ HIGH BLOOD PRESSURE
☐ HODGKIN DISEASE
☐ JAUNDICE
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ LUNG DISEASE MEDICAL IMPLANT

☐ MENTAL HEALTH, please specify:

_____

☐ ORGAN TRANSPLANT
☐ SJOGREN'S SYNDROME
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ SEXUALLY-TRANSMITTED INFECTIONS
☐ SICKLE CELL DISEASE
☐ STROKE
☐ THYROID DISEASE: HYPER OR HYPO
☐ TUBERCULOSIS
☐ ULCERS
☐ VERTIGO
☐ OTHER, please specify:

13. (WOMEN ONLY) ARE YOU PREGNANT OR SUSPECT YOU MAY BE?

☐ YES ☐ NO IF YES DUE DATE: _____

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

Dental History

1. ARE YOU IN PAIN OR DISCOMFORT AT THIS TIME? ☐ YES ☐ NO

   IF YES PLEASE SPECIFY:

   _____

2. HAVE YOU EVER HAD LOCAL ANAESTHETIC (FREEZING)? ☐ YES ☐ NO

   ANY COMPLICATIONS/DIFFICULTIES? ☐ YES ☐ NO

3. DO YOUR GUMS BLEED WHEN YOU BRUSH? ☐ YES ☐ NO ☐ SOMETIMES

4. DOES FOOD CATCH BETWEEN YOUR TEETH? ☐ YES ☐ NO

5. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH? ☐ YES ☐ NO

6. HAVE YOU EVER HAD PROBLEMS WITH YOUR JAW JOINT OF FACIAL MUSCLES (EG. POPPING, CLICKING, DIFFICULTY OPENING)? ☐ YES ☐ NO

7. HAVE YOU NOTICED YOUR BITE CHANGING? ☐ YES ☐ NO

8. ARE YOU NERVOUS ABOUT GOING TO THE DENTIST? ☐ YES ☐ NO

   IF YES PLEASE SPECIFY WHY (EG. PREVIOUS BAD EXPERIENCE, FEAR OF NEEDLES):

   _____

PATIENT/GUARDIAN SIGNATURE: DATE: _____