

# Medical History

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.

- 1 Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 2 When was your last medical checkup? \_\_\_\_\_
- 3 Has there been any change in your general health in the past year? If yes, please explain.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 4 Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_  
 \_\_\_\_\_
- 5 Do you have any allergies? If you answered yes, please list using the categories below:  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_  
 a) medications      b) latex/rubber products      c) other e.g. hayfever, foods
- 6 Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 7 Do you have or have you ever had asthma?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 8 Do you have or have you ever had heart or blood pressure problems?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 9 Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 10 Do you have a prosthetic or artificial joint?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 11 Have you ever been advised by a doctor to take antibiotics before dental treatment?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 12 Do you have any conditions or therapies that could affect your immune system  
 (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 13 Have you ever had hepatitis, jaundice, or liver disease?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_
- 14 Do you have a bleeding problem or bleeding disorder?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_



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15 Have you ever been hospitalized for any illnesses? If yes, please explain.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

16 Do you have or have you ever had any of the following? Please circle.

<input type="radio"/> chest pain, angina	<input type="radio"/> lung disease (e.g. emphysema, bronchitis)	<input type="radio"/> arthritis
<input type="radio"/> heart attack	<input type="radio"/> tuberculosis	<input type="radio"/> seizures (epilepsy)
<input type="radio"/> stroke	<input type="radio"/> cancer	<input type="radio"/> kidney disease
<input type="radio"/> shortness of breath	<input type="radio"/> steroid therapy	<input type="radio"/> thyroid therapy
<input type="radio"/> prosthetic heart valve	<input type="radio"/> diabetes	<input type="radio"/> diet pill therapy
<input type="radio"/> pacemaker	<input type="radio"/> stomach ulcers	<input type="radio"/> drug/alcohol dependency
<input type="radio"/> liver disease (e.g. cirrhosis, hepatitis)	<input type="radio"/> malignant hyperthermia	<input type="radio"/> mental/nervous disorder

17 Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

18 Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

19 Do you smoke or chew tobacco products? If yes, please indicate how much.  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

20 Women only: Are you pregnant or breast-feeding? If pregnant, when are you due?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

21 When did you last see a dentist? \_\_\_\_\_

22 Have you ever had orthodontics, gum surgery, oral surgery, wisdom teeth extraction?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

23 Does your jaw crack, pop, or hurt when opened? Has it ever locked open or closed?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

24 Would you like to hear about options to enhance your smile?  
 NO  NOT SURE / MAYBE  YES  \_\_\_\_\_

CURRENT LEGISLATION REQUIRES ALL DENTAL OFFICES TO IMPLEMENT A PRIVACY CODE FOR THE COLLECTION, USE, AND DISCLOSURE OF YOUR PERSONAL INFORMATION AND RECORDS. THIS POLICY EXPLAINS HOW OUR OFFICE WILL USE YOUR PERSONAL INFORMATION AND OUTLINES THE STEPS WE ARE TAKING TO PROTECT IT.

1. Only necessary information is collected about you to deliver safe and efficient patient care.
2. Only pertinent information is used to communicate with other treating healthcare providers, including specialists, dental laboratories, and peripheral dentists.
3. Your address and employer information is only used for efficient follow-up of treatment, care and billing, and to maintain contact.
4. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols.
5. Our privacy protocols comply with privacy legislation, standards of our regulatory body (the Royal College of Dental Surgeons of Ontario), and the law.

I UNDERSTAND THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE THAT DR. BAYLEY AND HIS ASSOCIATES CAN COLLECT, USE AND DISCLOSE MY PERSONAL INFORMATION AS SET OUT IN THE ABOVE POLICY. I ALSO GIVE PERMISSION FOR THE DOCTOR TO USE ANY PHOTOGRAPHS TAKEN FOR LECTURING OR EDUCATIONAL PURPOSES.

\_\_\_\_\_  
 DAY MONTH YEAR  
 Patient's / Parent / Guardian Signature Date

\_\_\_\_\_  
 DAY MONTH YEAR  
 Dentist's Signature Date