Great lakes DENTAL

MEDICAL HISTORY

Unit B - 1323 Michigan Ave. Sarnia Ontario N7S 4M6
Tel: (519) 542-3427 info@greatlakesdental.ca www.greatlakesdental.ca

Name:_____ Address:_____ Postal Code: _____

Date of Birth (yyyy/mm/dd):_____ Cell #:_____ Home #:_____

Occupation:_____ Insurance Company:_____ Group/ID#:_____

		YES	NO	?
1.	Have you ever had a serious illness requiring hospitalization or extensive medical care? _ _ _ _ _ _ _ _ _ _ _ Specify:_____	☐	☐	☐
2.	Are you presently under the care of a physician? _ If so, explain:_____	☐	☐	☐
3.	Have you had a medical examination in the last year? _	☐	☐	☐
4.	Do you use any prescription, non-prescription or herbal medicine regularly? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Specify: 1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____ 7)_____ 8)_____ 9)_____	☐	☐	☐
5.	Do you smoke? _ How many cigarettes/day?_____	☐	☐	☐
6.	Do you have an allergic conditions: i.e. Asthma, hay fever, latex, food or drug allergies? _ _ _ _ _ _ _ _ _ _ Specify:_____	☐	☐	☐
7.	Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? _ _ _ _ _ _ _ _ Specify:_____	☐	☐	☐
8.	Have you ever experienced any unusual reaction to any of the following? Please circle: _ _ _ _ _ _ _ _ _ _ _ Local anesthesia (freezing), aspirin, penicillin, erythromycin, iodine, sulfonamide, barbiturates (sleeping pills), codeine, or any other medicine? Explain:_____	☐	☐	☐
9.	Have you been warned about taking any prescription drug or medication? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ If so, explain:_____	☐	☐	☐
10.	Do you have or have you had any of the following? Please check all that apply: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	☐	☐	☐

☐ Heart murmurs/mitral valve prolapse	☐ Malignant hyperthermia	☐ AIDS or contact	☐ Hepatitis A/B/C	☐ Liver disease
☐ Stomach/intestinal problems	☐ Drug/Alcohol addiction	☐ HIV positive	☐ Herpes	☐ High/Low blood presure
☐ Joint replacement (hip, knee, ect)	☐ Anemia/Blood disorders	☐ Epilepsy or seizures	☐ Thyroid disease	☐ Cortisone/Steroid
☐ Mental or nervous disorder	☐ Stroke/Migraines	☐ Cancer	☐ Cold sores	☐ Taken Redux
☐ Organ transplant/Medical implant	☐ Heart attack/trouble	☐ Jaundice	☐ Kidney disease	☐ Taken Fen/Phen
☐ Hyper (hypo) glycemia	☐ Arthritis or rheumatism	☐ Tuberculosis	☐ Sinus trouble	☐ Other:
☐ Diabetes/Family history	☐ Scarlet/Rheumatic fever	☐ Lung disease	☐ Venereal disease	_____

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	YES	NO	?
11. Do you bruise easily or bleed abnormally? _	☐	☐	☐
12. Have you ever had radiation treatment or chemotherapy? _	☐	☐	☐

If so, explain:_____

DENTAL HISTORY

1.	Have you ever had an injury, surgery or x-ray therapy to your face or jaws? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	☐	☐	☐
2.	Have you had a dental exam in the past year? _	☐	☐	☐
3.	Were x-rays taken? _	☐	☐	☐
4.	Do your gums bleed, feel tender or swollen? _	☐	☐	☐
5.	Do you have any pain in your teeth because of heat, cold, sweets or chewing? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	☐	☐	☐
	If so, explain:_____			
6.	Do you ever clench or grind your teeth? _	☐	☐	☐
	If so, when:_____			
7.	Is there a specific problem you would like the dentist to address today? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	☐	☐	☐
	If so, explain:_____			
8.	Is another member of your family a patient at our office? _	☐	☐	☐
9.	Have you ever had orthodontic treatment? _	☐	☐	☐
10.	Do you wear a night guard? _	☐	☐	☐
11.	Have you ever had gum disease? _	☐	☐	☐
12.	Does floss ever tear between your teeth? _	☐	☐	☐
13.	Does food get stuck between your teeth? _	☐	☐	☐
14.	Do your teeth ever hurt when you bite hard? _	☐	☐	☐

Emergency Contact: _____ Tel #: _____

INFORMED CONSENT / GENERAL RELEASE

I, the undersigned state that I have provided an accurate and complete medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding the medical/dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostics and oral surgery procedures and services including the use of anesthetic as may be necessary. I also understand that I assume responsibility for any and all fees assocaited with these procedures and services.

PATIENT (PARENT or GUARDIAN) SIGNATURE: _____

IF PARENT or GUARDIAN, PLEASE PRINT NAME: _____

DOCTOR SIGNATURE: _____ DATE: _____