MIDTOWN DENTAL CENTRE

Preference for Appointment Reminders (check one)

□ *Text* □ *E-mail* □ *Phone Call*

HEALTH HISTORY FORM

Dr.□ Mr.□ Mrs.□ Ms.□

Name:_____
first *middle* *last*

Date of Birth:_____ Age:_____
mm/dd/yyy

Address: _____
box # *house #* *street name* *city* *province* *postal code*

Physician's Name: _____ Physician's Number:_____

Emergency Contact Information _____
Name *Relation* *Phone*

How did you hear about Midtown Dental Centre? ..... □ Website □ Google Referral: _____
Have you been hospitalized in the last 5 years?..... **Y** OR **N** Explain: _____
Have you ever had extensive medical care or surgery?..... **Y** OR **N** Explain: _____
Do you have any **allergies**? (i.e. antibiotics, metal, latex)..... **Y** OR **N** Explain: _____
When was your last physical exam with your family doctor (approx.)? _____

Have you ever experienced any unusual reactions to the following? **(please check all that apply)**

□ Local Anesthetics(freezing) □ Aspirin □ Penicillin □ Iodine □ Sulfonamide (Sulfa) □ Barbiturates

Explain:_____

Have you ever been advised to not take a certain drug/medication..... **Y** OR **N** Explain:_____

Do you have or have ever had any of the following? **(check all that apply):**

☐ Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ AIDS	□ Liver Disease
☐ Stomach/Intestinal Problems	☐ Drug/Alcohol Addiction	☐ Joint Replacement	□ Herpes
☐ Hepatitis A or B or C	☐ Asthma	☐ Heart Attack	□ Jaundice
☐ Mental or Nervous Disorder	☐ Cortisone/Steroid Therapy	☐ Lung Disease	□ Cold Sores
☐ High or Low Blood Pressure	☐ Sinus Trouble	☐ Diabetes	□ Thyroid Disease
☐ Hyper/Hypoglycemia	☐ Arthritis or Rheumatism	☐ Tuberculosis	□ Cancer
☐ Scarlet or Rheumatic Fever	☐ Epilepsy or Seizures	☐ Stroke	□ Kidney Disease

Notes: _____

Have you ever had any known contact with the HIV..... **Y** OR **N** Explain: _____
Has any member of your family had diabetes..... **Y** OR **N** Explain: _____
Do your ankles swell during the day?..... **Y** OR **N** Explain: _____
Have you had any sudden weight changes recently?..... **Y** OR **N** Explain: _____
Do you bruise easily?..... **Y** OR **N** Explain: _____
Do you have any blood disorders? (i.e. haemophilia, anemia)... **Y** OR **N** Explain: _____
Do you bleed for a prolonged period after a cut/wound?..... **Y** OR **N** Explain: _____
Have you ever had chemotherapy?..... **Y** OR **N** Explain: _____
Have you had radiation to the head or neck?..... **Y** OR **N** Explain: _____
Have you ever fainted?..... **Y** OR **N** Explain: _____
Do you ever experience shortness of breath? Or Chest Pain?.... **Y** OR **N** Explain: _____
Have you had any organ transplants or medical implants?..... **Y** OR **N** Explain: _____
Is your eye sight : ☐ Good ☐ Adequate ☐ Poor

Do you have any disease, condition or past medical history that the doctor should know about? **Y** OR **N**

Explain: _____

Have you ever been diagnosed with or treated for Osteoporosis or Osteopenia?...**Y** OR **N** Explain: _____

Have you ever taken any of the following medications? **(check all that apply)**

□ Etidronate (Didronel)	□ Risedronate (Actonel)	□ Denosumab (Prolia)	□ Alendronate (Fosamax)
□ Tiludronate (Skelid)	□ Ibandronate (Boniva)	□ Zoledronate (Zometa)	

Doctor's Initials _____

Female Patient Only
Are you pregnant?.....**Y** OR **N** How Many Months Pregnant:_____ Name of Obstetrician: _____

Please list all prescriptions and non-prescriptions Please include dose and the frequency

Medications	Approx. Start Date	Medications	Approx. Start Date
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Dental History

How often have you visited the dentist 3 mos.□ 6 mos.□ 9 mos.□ Once a year□
Name of Former Dentist (if known): _____ Last Dental Visit (approx.)_____

Do you like your smile?.....**Y** OR **N** Is there anything you want to change/improve? Explain: _____
Have you been given oral hygiene instruction in brushing?..... **Y** OR **N**.. How often do you brush? _____
Have you been given oral hygiene instruction in flossing?..... **Y** OR **N**.. How often do you floss? _____
Are your teeth sensitive?..... **Y** OR **N**.. Location:_____
Do your gums bleed?..... **Y** OR **N**.. ☐ Spontaneously ☐ Only when brushing/flossing
Do you gag easily?..... **Y** OR **N**.. ☐ Mild ☐ Severe
Do you chew on one side only?..... **Y** OR **N**.. Explain:_____
Have you had any growths or sores in your mouth?..... **Y** OR **N**.. Explain:_____
Do you smoke?..... **Y** OR **N**.. cigarette □ marijuana □ other □ Pack per day: _____

TMJ Screening

Do you ever wake up with a headache, muscle pain or sore jaw?.....**Y** OR **N**..
Are you aware of clenching/grinding your teeth at all through the day/night?.....**Y** OR **N**..
Do you currently wear a night guard or any other dental apparatus?.....**Y** OR **N**..
Do you snore heavily throughout the night?.....**Y** OR **N**..
Have you ever experienced lockjaw?.....**Y** OR **N**..
Does your jaw crack or pop when opening/closing?.....**Y** OR **N**..

Notes: _____

Check all of the following that you are interested in:

☐ Orthodontics
☐ Snoring/Apnea treatment
☐ Replace missing teeth
☐ Repair chipped teeth
☐ Improve bite
☐ Implants
☐ Improve gum health
☐ Closing spaces
☐ Sports guard
□ Whitening
□ Improve smile
□ Crowns

I hereby certify that the above information is accurate and complete and that I have not knowingly omitted any information. I have had the opportunity to ask question and receive answers to any questions regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that the information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

X_____ Date:_____
Signature of Patient/or Guardian (18yrs & under) *mm/dd/yyyy*

X_____ Date:_____
Please Print Name of Patient/or Guardian (18 yrs & under) *mm/dd/yyyy*

Doctor's Initials_____