DENTAL SPECIALISTS GROUP
YOUR SMILE OUR SPECIALTY®

MEDICAL HISTORY FORM

Title: ____ First Name: _____Last Name: _____ Preferred Name:_____

Address: _____ City: _____ Province: _____ Postal Code:_____

Tel: _____ Cellular: _____ Work: _____

Email: _____Contact Method: _____ Occupation: _____

Employment/ School _____Emergency Contact: _____

Tel:_____ Emergency Relationship _____

Date of Birth: M/D/Y_____ Gender: _____ Are you available on short notice?_____

If you were referred to our office, by whom were you referred by? _____

MEDICAL INFORMATION:

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your Dental Treatment. Please answer the following questions.

Are you seeing a Family Physician? If so, please enter the name, number and date of last visit. ☐Yes ☐No

_____

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. ☐Yes ☐No

_____

Have you ever had a serious head and or neck injury? If so, please explain. ☐Yes ☐No

_____

For Women Only: Taking Birth Control Pills? ☐Yes ☐No Are you or could you be pregnant ☐Yes ☐No

If yes, what is the expected delivery date? _____

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Please go over the following section and indicate which of the following apply to you. If you add any further information, please enter it at the end.

	YES	NO
AID/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joins	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
COVID-19	☐	☐
Chemotherapy	☐	☐
Chest pain	☐	☐
Circulation Problems	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy/Seizures	☐	☐
Fainting	☐	☐

	YES	NO
Glaucoma	☐	☐
Head/Neck Injury	☐	☐
Heart Attack Failure	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Hyperthyroidism	☐	☐
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
High Blood Pressure	☐	☐
Kidney Problems	☐	☐
Liver Problems	☐	☐
Lung Disease	☐	☐
Mental/Nervous	☐	☐
Organ Implant	☐	☐
Sickle Cell Disease	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Endocrine Problems	☐	☐

Please enter details or any further information: _____

List all drugs/medications you are taking (if you are taking 8+ medications, please attach a separate list):

Name	Reason	Dose	Frequency

Other: _____

If yes to Antibiotic, please indicate the name:_____

If you have ever been advised against any type of medication, please list them: _____

If you have any allergic conditions, please list them. This can include asthma, hay fever, food allergies, and metal or latex allergies.

_____

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	YES	NO
Have you ever had any joint replacement surgery?	☐	☐
- If yes, please indicate the type of surgery		
- If yes, please indicate the date of surgery		
Have you been told by your MD you need to take premedication (antibiotics) one hour before your dental appointment?	☐	☐

If yes, please indicate:

Name of Antibiotic	Reason	Dosage	Amount

	YES	NO
Do you use any form of Tobacco?	☐	☐
- If yes, please indicate no. cigarettes per day		
- If yes, please indicate no. of years		
Are you wearing a nicotine patch?	☐	☐
Are you dependant on alcohol or drugs?	☐	☐
Do you bruise easily or bleed severely when cut?	☐	☐
Do you have severe earaches, ear, throat infections or headaches?	☐	☐
Do you wear glasses or contact lenses?	☐	☐

DENTAL INFORMATION:

If the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with application laws. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had Orthodontics (braces) treatment?	☐	☐
Do you have headaches or migraines?	☐	☐
Are your sensitive to cold, hot, sweets or pressure?	☐	☐
Have you had any difficult extractions?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Have you ever worn a bite plate or other appliances?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you ever have difficulty opening or closing your jaw?	☐	☐
Have you ever had a head, neck or jaw injury?	☐	☐
Do you have any loose teeth, or have they ever shifted?	☐	☐
Have you had any pain in your jaw area?	☐	☐
Does food frequently get stuck in your teeth?	☐	☐
Have you ever had periodontal treatment?	☐	☐

Please enter details or any further information:

_____

_____

_____

Please give a brief description of your Oral Hygiene Habits: _____

If you have a current dental problem, please describe: _____

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Do you have any concerns about having Dental Treatment? If so, please explain: _____

Are you happy with the appearance of your teeth? If no, please explain: _____

Do you ever feel nervous about visiting a Dentist? If so, please explain: _____

Please enter your Dentist name and location: _____

Date of you last X-Rays: _____ Date of your last teeth cleaning: _____Date of your last Dental Exam: _____

What can we do to make your smile? Check all that apply, and we will get back to you with more information about your inquiry:

☐ Oral Conscious Sedation	☐ Veneers	☐ Broken/ Cracked Teeth	☐ Dental Implants
☐ Invisalign Teeth Straightening	☐ Gummy Smile	☐ Total Smile Makeovers	☐ Replace Missing Teeth
☐ One Hour In-House Whitening	☐ Cosmetic Dentures	☐ White Fillings	☐ Replace Metal Fillings
☐ Rejuvenate Worn/ Stained Teeth	☐ Eliminate Gaps	☐ Sleep Apnea/ Snoring	☐ Correct Misaligned Teeth

Do you have:

☐ CUD-Complete Upper Denture

Present denture received: _____ Age when you got your first CUD: _____ Year:_____

☐ CLD Complete Lower Denture

Present denture received: _____ Age when you got your first CUD: _____ Year:_____

☐ RPUD-Removable Partial Upper Denture

Present denture received: _____ Age when you got your first CUD: _____ Year:_____

Your present RPUD is made of:
□Metal and plastic □Plastic/Wire hooks

Replacing:
□All back teeth □All front teeth □Some back teeth □Some front teeth

Do you need denture adhesives? □Yes □No

Would you like to anchor your denture to your jaw bone more securely? □Yes □No

If you were to change anything in the next denture, it would be:

□Colour □Shape □Teeth size □Length □Width □Arrangement

□Distance from chin to nose □Amount they show when you smile

Patient Signature_____ Clinician Signature_____

Date_____ Date_____