Associated Endodontists

Dr. Lisane Paquette Dr. Andrew Gaffen Dr. Helena Lim

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MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

Mr./Miss/Mrs./Ms./Dr.

Name: _____

Date of Birth: ____ / ____ / ____
Day Month Year

Address (Home):

_____
Street

_____
City Province Postal Code

Phone (home):_____

Phone (business):_____

Email address:_____

Occupation:_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name:_____

Relationship:_____

Day-Time Phone:_____

Name Of Family Doctor:

_____

Name of Medical Specialist: _____

Area of Specialty: _____

Name of referring dentist:

_____

Do you have insurance? ☐Yes ☐No If yes, please complete the attached form.

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 time or have you been treated within the past year?
   If so, why? _____ ☐ Yes ☐ No ☐ Not Sure/Maybe
2. Has there been any changes in your general health in the past year? ☐ Yes ☐ No ☐ Not Sure/Maybe
   If yes, please explain: _____
3. Please list all the medications you are taking_____
   _____
4. Please list all the allergies you have using the following categories:
   Medications: _____
   Latex/rubber products: _____
   Other (e.g. hay fever, foods): _____
5. Describe all adverse reactions you may have to medications: _____
   _____
6. Are you suffering from asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe
7. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not Sure/Maybe
8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ☐ Yes ☐ No ☐ Not Sure/Maybe
9. Do you have a prosthetic or artificial joint (e.g. hip or knee)? ☐ Yes ☐ No ☐ Not Sure/Maybe
10. Are you required to take antibiotics on a **routine** basis before most dental appointments (e.g. after hip replacement, heart problems, etc.)? ☐ Yes ☐ No ☐ Not Sure/Maybe
11. Do you have any conditions or therapies that could affect your immune system, (e.g. leukemia, AIDS, HIV Infection, radiotherapy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/Maybe
12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe
13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain:
    _____ ☐ Yes ☐ No ☐ Not Sure/Maybe
15. Do you have or have you ever had any of the following? Please check.

☐ **chest pain, angina**	☐ **shortness of breath**	☐ **pacemaker**	☐ **steroid therapy**	☐ **seizures (epilepsy)**	☐ **drug/alcohol dependency**
☐ **heart attack**		☐ **lung disease**	☐ **diabetes**	☐ **kidney disease**	
☐ **stroke**	☐ **prosthetic heart valve**	☐ **tuberculosis**	☐ **stomach ulcers**	☐ **thyroid disease**	
		☐ **cancer**	☐ **arthritis**	☐ **diet pill therapy**	

16. Are there any conditions or diseases not listed above that you have or have had? ☐ Yes ☐ No ☐ Not Sure/Maybe
    If so, please list: _____
17. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe
18. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe
19. **For Women Only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____