DENTISTRY ON UNIVERSITY

154 University Ave. Suite 100
Toronto ON M5H 3Y9

Name _____ E-mail_____

Address _____

Phone numbers (H) _____ (W) _____ (M) _____

Gender _____ Date of birth _____ Occupation _____

Parent/guardian (if client is a minor) _____

Physician's name, address and phone number

_____

_____

Emergency contact and phone number

_____

Referral source _____

MEDICAL HISTORY

Any change in your health in the past year? ☐ Yes ☐ No

Date of last physical examination? _____

Are you under the care of a physician/specialist? ☐ Yes ☐ No

If yes, name and type of specialist _____

Have you been hospitalized or had a serious illness or operation? ☐ Yes ☐ No

Please list any medical conditions that run in your family? _____

Medications – prescribed, over-the-counter or herbal remedies? Please list (note dose and frequency)

_____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____ Years smoked? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per day _____/week_____

Are you taking / do you take recreational drugs? ☐ Yes ☐ No

Please indicate any previous adverse reactions to:

☐ Medication _____ ☐ Drugs _____

☐ Anesthetic _____ ☐ Metals _____

☐ Foods _____ ☐ Latex _____

Check all that apply:

Cardiovascular

☐ Congenital heart disease, heart attack, chest pain

☐ Pacemaker, artificial heart valves

☐ History of infective endocarditis

☐ Heart failure, swollen ankles

☐ Shortness of breath, heart surgery/bypass

☐ High blood pressure, low blood pressure

Blood conditions

☐ Cerebrovascular accident (stroke)

☐ Haemophilia, bruise easily, heal slowly, prolonged bleeding

☐ HIV, AIDS, lupus, anaemia

☐ History of blood transfusion

Respiratory conditions

☐ Persistent cough or cold

☐ Tuberculosis, emphysema, asthma/hay fever

☐ Bronchitis, pneumonia, sinus infection

☐ Shortness of breath, COPD

GI/Digestive system

☐ Stomach ulcers/acid reflux

☐ Jaundice, liver disease

Genitourinary System

☐ Kidney disease/disorder, hepatitis (A, B or C, other)

☐ Sexually transmitted diseases/infections, syphilis, gonorrhea, herpes , HPV

Bones and joints

☐ Arthritis, swollen joints, inflammatory rheumatism

☐ Artificial joints (hip, knee or joint), osteoporosis

Neurological/Psychological Conditions

☐ Fainting spells, frequent exhaustion, frequent headaches

☐ Seizures, epilepsy

☐ Paralysis, Alzheimer's disease

☐ Multiple sclerosis/demyelinating disease, Parkinson's disease

☐ Clinical depression/anxiety/psychiatric treatment

Endocrine

☐ Diabetes controlled/uncontrolled – if yes, Type I (insulin dependent) Type II

☐ Thyroid disease (hypothyroidism, hyperthyroidism)

☐ History of cortisone treatment

Women

☐ Pregnancy

☐ Nursing

☐ Contraception/Birth control

☐ Hormone replacement

Other

☐ History of organ transplant

☐ Eye disease, glaucoma

☐ History of radiation

☐ History of chemotherapy

☐ Any other condition or disease not previously mentioned?

Dental History

What dental conditions concern you at the present time? _____

How often do you receive dental treatment or dental hygiene care? _____

Date of last dental/dental hygiene visit? _____

Any previous complications following local anesthetic (freezing) or dental treatment? ☐ Yes ☐ No

Have you ever experienced any of the following?

- ☐ Sensitive teeth (hot or cold)
- ☐ Bleeding gums, sore gums
- ☐ Loose teeth
- ☐ Dry mouth, bad breath
- ☐ Sinus problems
- ☐ Sore jaw, jaw clicks or pops on opening or closing, difficulty chewing, grinding of teeth
- ☐ Any accident, injury or surgery to your face, jaw or teeth
- ☐ Mouth sores, cold sores
- ☐ Difficulty swallowing, burning sensation
- ☐ Toothache, fractured or broken fillings, abscess
- ☐ Fractured or broken filling, abscess
- ☐ Yellowing or discolouration of teeth
- ☐ Tooth extractions
- ☐ Dental implants, root canals
- ☐ Gum/jaw surgery, orthodontics/braces
- ☐ Prolonged bleeding after dental treatment
- ☐ Other _____

Current Oral Condition

What is your current oral homecare routine? _____

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

In order that we may be sensitive to your needs, please tell us of any unpleasant experiences you may have had related to oral care. _____

_____

Is there anything you would like to change about your smile? _____

_____

Authorization and Release

I acknowledge that I have provided accurate medical and dental history. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor *Date*

FOR OFFICE USE ONLY----------

Reviewed by _____ *Date:* _____

Dr. Gina Lee