Ainslie Street
DENTAL CENTRE

CLIENT NAME

PREFERRED NAME _____ TODAY'S DATE _____

ADDRESS/POSTAL CODE _____ DATE OF BIRTH _____

EMAIL _____ HOME PHONE _____

EMERG. CONTACT/PHONE _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. MEDICAL ALERT

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	□	□
2. Are you under care of a medical specialist?		
3. Have you ever been hospitalized for any surgical operation or serious illness?		
4. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?		
5. Do you use tobacco?	□	□
6. Do you use alcohol, cocaine or other drugs?	□	□
7. Have you ever had any adverse or unusual reactions to any medications or injections, or any type of environmental or food allergy(i.e. penicillin's or other antibiotics, aspirin, codeine, local anaesthetic, latex)?	□	□
8. WOMEN ONLY		
a) Are you pregnant or think you may be pregnant?	□	□
b) Are you nursing?	□	□
c) Are you taking birth control pills?	□	□

9. **CIRCLE Yes or N**o if you have or had any ot the following Medical Condition(s), **PLEASE EXPLAIN**….

1. Heart Attack Date:		Y/N	21. Kidney Disease		Y/N
2. High/Low Blood Pressure		Y/N	22. Liver Disease		Y/N
3. Heart Disease		Y/N	23. Asthma		Y/N
4. Angina		Y/N	24. Respiratory Problems		Y/N
5. Cardiac Arrhythmias		Y/N	25. Emphysema		Y/N
6. Heart Murmur		Y/N	26. Tuberculosis		Y/N
7. Cardiac Pacemaker		Y/N	27. Steroid Therapy		Y/N
8. Rheumatic Fever Date:		Y/N	Date:		
9. Swollen Ankles		Y/N	28. Hayfever/Environmental Allergies		Y/N
10. Easily Winded/Shortness of Breath		Y/N	29. Glaucoma		Y/N
11. Fainting During Dental Tx		Y/N	30. Rheumatoid/Osteo Arthritis		Y/N
12 Stroke Date & Type		Y/N	31. Joint Replacement or Implants		Y/N
13. Coumadin/Warafin		Y/N	Date:		
Dosage:			32. Chrons/Ulcerative Colitis		Y/N
Recent INR			33. Ulcers		Y/N
14. Anemia		Y/N	34. Epilepsy/Seizures		Y/N
15. Cancer Date & Type		Y/N	Any Auras		
Remission Date:			35. Sexually Transmitted Diseases		Y/N
16. Radiation/Chemotherapy		Y/N	36. Hepatitis/Jaundice Type:		Y/N

17. Leukemia	Y/N	37. AIDS/HIV	Y/N
18. Recent Weight Loss/Diet Therapy	Y/N	38. Any other Immune-Suppressant Conditions	Y/N
19. Diabetes Type:	Y/N	39. Clotting or Bleeding Disorders	Y/N
20. Thyroid Disease Type:	Y/N	40. Other	Y/N

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	□	□	8. Do you have frequent headaches?	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□	9. Do you clench or grind your teeth?	□	□
3. Are your test sensitive to sweet or sour liquids/foods?	□	□	10. Do you bite your lips or cheeks frequently?	□	□
4. Do you feel pain to any of your teeth?	□	□	11. Have you had any difficult extractions in the	□	□
5. Do you have any sores or lumps in or near your mouth?	□	□	past?		
6. Have you had any head or neck or jaw injuries?	□	□	12. Have you had any orthodontic treatment?	□	□
7. Have you ever experienced any of the following			13. Have you ever had prolonged bleeding	□	□
problems in your jaw?	□	□	following extractions?		
a) Clicking?	□	□	14. Have you ever had instruction on the correct	□	□
b) Pain (joint, ear, side of face)?	□	□	method of brushing your teeth?	□	□
c) Difficulty in opening or closing?	□	□	15. Have you ever had instructions on the care	□	□
d) Difficulty in chewing ?	□	□	of your gums?		
			pg 2	□	□

Risk Assessment	Brushing		Rinsing	
	Flossing		Adjuncts	
	Smoking		Stress	

SIGNATURE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ YYYY/MM/DD

Patient, Parent or Guardian

Update

Health Changes Dated:

Hospitalization/Surgery(s):

Physician's Name

Physician's Phone

CURRENT MEDICATIONS

1

2

3

4

Last Physical Exam

Allergies?

Patient Signature:

Staff Initials

Update

Health Changes Dated:

Hospitalization/Surgery(s):

Physician's Name

CURRENT MEDICATIONS

1

2

3

4

Last Physical Exam

Physician's Phone _____ Allergies? _____

Patient Signature: Staff Initials

Update

CURRENT MEDICATIONS

Health Changes Dated: _____ 1 _____

_____ 2 _____

3 _____

Hospitalization/Surgery(s): _____ 4 _____

_____

Last Physical Exam _____

Physician's Name _____

Physician's Phone _____ Allergies? _____

Patient Signature: Staff Initials