Westbrook Dental Centre
Adult - Medical History

Please complete the following medical and dental questions as accurately as possible.
This is essential in order for the dentist to provide safe and optimal dental care.

Patient Name : MEDICAL ALERT :

Date: 9-Nov-2018

Name of Medical Doctor : Phone Number:

When did you last see your medical doctor?

Reason for visit:

1. Are you presently being treated for any medical condition? ☐ Yes ☑ No
   Specify:
2. Has there been a change in your health in the last year? ☐ Yes ☑ No
   Specify:
3. Have you ever been hospitalized? ☐ Yes ☑ No
   Specify:
4. Do you take any medication? ☐ Yes ☑ No
   Drug: Reason:
   Drug: Reason:
5. Have you ever had a negative reaction to any drug? ☐ Yes ☑ No
   Specify:
6. Do you have any allergies? ☐ Yes ☑ No
   Specify:
7. Have you ever had heart disease or heart murmur? ☐ Yes ☑ No
8. Have you ever had rheumatic fever? ☐ Yes ☑ No
9. Have you ever had joint/hip replacement? ☐ Yes ☑ No
10. Have you ever been advised that you need to take antibiotics before dental treatment? ☐ Yes ☑ No
11. Do you have asthma? ☐ Yes ☑ No
12. Have you ever taken cortisone or steroids? ☐ Yes ☑ No
13. Do you have abnormal bleeding or do you bruise easily? ☐ Yes ☑ No
14. Have you had any weight change lately? ☐ Yes ☑ No
15. Have you had chemotherapy or radiation therapy? ☐ Yes ☑ No
    Specify:
16. Have you ever had any injury, surgery, or radiation therapy to your head or neck? ☐ Yes ☑ No
    Specify:
17. Do you suffer from frequent headaches? ☐ Yes ☑ No
18. Do you suffer from dizziness of fainting spells? ☐ Yes ☑ No

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19. Do you ever have unexplained shortness of breath or chest pains? ☐ Yes ☑ No

20. Do you have or have you ever had any of the following:

☐ Arthritis	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Angina	☐ Epilepsy	☐ Hyper/Hypoglycemia	☐ Sinus Trouble
☐ Anemia	☐ Heart Attack	☐ Jaundice	☐ STD's
☐ AIDS	☐ Heart Murmur/Condition	☐ Joint/Hip Replacement	☐ Swollen Ankles
☐ Blood Disorder	☐ Heart Valve Disorder	☐ Kidney Disease	☐ Thyroid Disease
☐ Cancer	☐ High/Low Blood Pressure	☐ Lung Disease	☐ Tuberculosis
☐ Diabetes	☐ Hepatitis	☐ Nervous/Mental Disorder	☐ Ulcer

21. Do you have or have you ever had any condition not listed above? ☐ Yes ☑ No

Specify:

22. Do you smoke? ☐ Yes ☑ No

Specify:

WOMEN ONLY

23. Are you pregnant or are you attempting to become pregnant? ☐ Yes ☑ No

Specify:

24. Are you taking birth control pills? ☐ Yes ☑ No

Specify:

Dental history

1. Are you experiencing any discomfort at this time? ☐ Yes ☑ No
2. Have you been under regular care of a dentist? ☐ Yes ☑ No
3. When was your last dental visit? ☐ Yes ☑ No

What was done at that time?

4. Do your gums feel tender or swollen? ☐ Yes ☑ No
5. Have you ever had periodontal therapy or been told you have gum disease? ☐ Yes ☑ No
6. Do you have any loose teeth? ☐ Yes ☑ No
7. Does your jaw pop or crack? ☐ Yes ☑ No
8. Do you have any pain in your jaw or ear area ? ☐ Yes ☑ No
9. Do you gag easily? ☐ Yes ☑ No
10. Have you ever been given LOCAL anaesthetic - better known as FREEZING? ☐ Yes ☑ No

If "YES", were there any complications? ☐ Yes ☑ No

Specify:

11. Have you ever been given GENERAL anaesthetic? ☐ Yes ☑ No

If "YES", were there any complications? ☐ Yes ☑ No

Specify:

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12. Are you aware of any lump or swelling in your mouth? ☐ Yes ☑ No
Specify:

13. Are you satisfied with the appearance/colour of your teeth? ☐ Yes ☑ No
Specify:

14. Are you anxious to keep your natural teeth? ☐ Yes ☑ No

15. Are you tense during dental visits? ☐ Yes ☑ No

16. Are you interested in a way to calm your nerves? ☐ Yes ☑ No
Describe in your own words what you would like done with your teeth:

20. Do you have or have you ever had any of the following:

☐ Loose teeth	☐ Bleeding gums	☐ Sore gums
☐ Sensitive teeth	☐ Bad breath	☐ Popping or clicking jaw
☐ Ear ache	☐ Neck pain	☐ Missing teeth
☐ Headache	☐ Unexplained nosebleeds	☐ Gagging
☐ Spaced or crooked teeth	☐ Unsatisfactory dentures	☐ Unsatisfactory crown or bridge

i certify that the above medical and dental information is true and complete to the best of my knowledge. I authorize the dentist to contact my physician if required.

I authorize Westbrook Dental Centre to contact me in regards to dental treatment.

Patient Signature: Print and Sign Current Date: 9-Nov-2018

Print

Please print, sign, and bring this document to your next visit to our clinic. It will save you time.

If the print button doesn't work in your browser, try to find the print option by searching on your browser's tabs or using the 2nd button of your mouse.