Patient Medical Information

CORYDON DENTAL CENTRE

Wednesday, February 25, 2015

Title _____ **First Name** _____ **Surname** _____

Health Card Number _____ **Email** _____

Date of birth _____ **Occupation** _____ **Employer** _____

Address _____ **Referred By** _____

_____ **Postal Code** _____

Tel Contact **Home:** _____ **Work:** _____

Mobile: _____

Emergency Contact _____ **Emergency Contact Number** _____

Are you being treated for any medical condition at the present or or have you been treated within the last year?

Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal suplements of any kind?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

_____

_____

_____

_____

Do you have any allergies? If you answered yes, please list using the categories below:

Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?

Yes ☐ No ☐ Not Sure ☐

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?

Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?

Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? _____

Do you have a prosthetic or artificial joint?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have bleeding problem or bleeding disorder?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

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 ☐

Do you have any of the following? Please Check

☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Sexually Transmitted Infection
☐ Angina	☐ Emphysema	☐ Lung Disease	☐ Shortness of Breath
☐ Anemia	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Arthritis	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Cancer	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Chest Pain	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 1	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 2	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

If under 18 years of age, please specify guardian name and phone number.

_____

_____

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

_____

_____

OTHER MEDICAL

_____

_____

OTHER

_____

_____

Patient Dental History

CORYDON DENTAL CENTRE

Thursday, March 19, 2015

When was your last dental visit? _____

When did you last have dental x-rays taken? _____

How often do you brush your teeth? _____

How often do you floss? _____

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐	☐
Have you ever had any implant surgery in your jaw or either jaw joints?	☐	☐	☐

If you answered yes to the last question, who performed the surgery and when was it done?

_____ Date _____

Are you being followed-up by a dentist specialist? _____

Please list anything not mentioned above regarding your past dental history:

_____

_____