THE TOOTH PLACE
BOLTON MEDICAL CENTER
12295 Hwy 50 Unit 211, Bolton, ON L7E 1M2
905 857 1791 | info@thetoothplace.ca

Medical History Questionnaire:

Medical Alert

Name: MR/MISS/MRS/MR/DR

Date of Birth: (Day/Month/Year)

Address: (Home)

Phone__________________________________

Occupation:_______________________________ Who referred you to our office?________________

In case of emergency, we should notify:

Name:_________________________________ Relationship:______________________________

Phone:__________________________________

Name of Family Doctor______________________ Phone number_______________________________

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 currently being treated for any medical condition or have you been treated within the past year? If yes, please explain a. yes b. no c. not sure/maybe

____

2. When was your last medical checkup? ____

3. Has there been any change in your general health in the past year? If yes, please explain

a. yes b. no c. not sure/maybe

4. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes,

List them: a. yes b.no c. not sure/maybe ____

5. Do you have any allergies? If yes, please list them using the categories below

a. yes b. no c. not sure/maybe

a. medications____

b. latex/rubber products____

c. other (e.g. hay fever, seasonal/environmental/foods) _____________________________________

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, explain

____

6. Do you or have you ever had asthma? a. yes b. no c. not sure/may

7. Do you have, or have you ever had any heart or blood pressure problems? A. yes b.no c. not sure

8. Do you have, or have you ever had a replacement or repair of a heart valve, an infection of the

9. Heart, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e.

10. Congenital heart disease) or a heart transplant? A. yes b. no c. maybe/not sure

11. Do you have prosthetic or artificial joint? A. yes b.no c. not sure/maybe

12. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia?

AIDS, HIV infection, radiotherapy, chemotherapy)? A. yes b.no c. not sure/maybe

Have you ever had hepatitis, jaundice, or liver disease? A. yes b. no c. not sure/maybe

Do you have a bleeding problem or bleeding disorder? A. yes b. no c. not sure/maybe

Have you ever been hospitalized for any illnesses or operations? If yes, please explain

A. yes b. no c. not sure/maybe

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Do you have or have you ever had any of the following? Please check

chest pain, angina

- heart attack
- rheumatic fever
- stroke, TIA

steroid therapy
diabetes
thyroid disease

- heart murmur
- mitral valve prolapses
- tuberculosis
- cancer
- pacemaker
- lung disease
- stomach ulcers
- arthritis
- drug/alcohol/cannabis/use or dependency
- seizures (epilepsy)
- kidney disease
- shortness of breath
- osteoporosis medications e.g. Fosamax, Actonel

Are there any conditions or diseases not listed above that you have or have had? If yes, please

Explain a. yes b.no c. not sure/maybe

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

Heart disease) a. yes b.no c. not sure/maybe

Do you smoke or chew tobacco products? A. yes b.no c. not sure/maybe

Are you nervous during dental treatment A. yes b. no c. not sure/maybe?

Are you breastfeeding or pregnant? If pregnant, what is your expected delivery date?

____

Do you identify as a patient with disability? If yes, please explain a. yes b. no c. not sure

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

Patient/Patient/ Guardian signature_____________________________Date: ________________

Dentist Signature____Date_________________

A patient's **medical history** is a vital part of his or her **dental history** and increases the **dentist's** awareness of diseases and medication which might interfere with the patient's **dental** treatment.

If you have any further questions or concerns, please do not hesitate to contact one of our team members.

THANK YOU.