Brampton Dental Arts
Where we create smiles

ADULT MED HISTORY - HEALTH/DENTAL FORM

Health History

Patient Name *

First Name Last Name

Gender *

Date: *

Month Day Year

Medical Alert

Condition:

Premedication:

Have you visited a physician for a medication condition in the past two years?

Yes No

If yes, please explain

Physician:

Phone:

Area Code Phone Number

When was your last visit to a Physician?

Last complete physical examination?

Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Or have you recently taken any?

Yes No

If yes, please list:

Have you been hospitalized in the past two years?

Yes No

Describe

Have you ever reacted adversely to any of the following?

Antibiotics– Penicillin. * ◯ Yes ◯ No

Sulfonamide * ◯ Yes ◯ No

Other Antibiotics * ◯ Yes ◯ No

Describe *

Asprin * ◯ Yes ◯ No

Barbiturates (sleeping pills) * ◯ Yes ◯ No

Codeine * ◯ Yes ◯ No

Darvon * ◯ Yes ◯ No

Local Anesthetic (freezing) * ◯ Yes ◯ No

Nitrous oxide * ◯ Yes ◯ No

Any other medication * ◯ Yes ◯ No

Please list *

Have you ever been advised against taking any specific type of medication? * ◯ Yes ◯ No

Describe *

Do you have any of the following?

Asthma * ◯ Yes ◯ No

Hay Fever * ◯ Yes ◯ No

Food Allergies * ◯ Yes ◯ No

Metal or Latex Allergies * ◯ Yes ◯ No

Skin Rashes * ◯ Yes ◯ No

Hives * ◯ Yes ◯ No

Any other allergic condition * ◯ Yes ◯ No

Describe *

Has any family member had diabetes? * ◯ Yes ◯ No

Describe *

Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? * ◯ Yes ◯ No

Describe *

Do your ankles, feet or hands swell? * ◯ Yes ◯ No

Describe *

Has your weight, appetite or energy level changed dramatically recently? * ◯ Yes ◯ No

Describe *

Do you experience shortness of breath or chest pain when talking or climbing stairs? * ◯ Yes ◯ No

Describe *

Do you follow a special diet? * ◯ Yes ◯ No

Describe *

Have you recently tested HIV positive? * ◯ Yes ◯ No

Describe *

Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? * ◯ Yes ◯ No

Describe *

Have you ever had any injury or surgery to your face or jaws? *
Yes No

Describe *

Do you wear eyeglasses or contact lenses? *
Yes No

Describe *

Do you have any hearing difficulties? *
Yes No

Describe

Do you smoke or use any other forms of tobacco? *
Yes No

Are you wearing the transdermal nicotine patch? *
Yes No

Describe

Are you alcohol and/or drug dependent?
Yes No

Have you received treatment?
Yes N0

Describe

Indicate Which of the Following You Presently Have or Ever Had

A.I.D.S *
Yes No

Arthritis / Rheumatism *
Yes No

Blood disorders *
Yes No

Circulation problems *
Yes No

Diabetes
Yes No

Fainting or dizzy spells *
Yes No

Head / neck injuries *
Yes No

Heart pacemaker *
Yes No

Hepatitis A *
Yes No

Heart pacemaker
Yes No

Herpes *
Yes No

Hyper (Hypo) Glycaemia *
Yes No

Kidney disease *
Yes No

Malignant hyperthermia *
Yes No

Organ transplant/ medical transplant *
Yes No

Rheumatic / Scarlet fever *
Yes No

Stomach / intestinal problems *
Yes No

Tuberculosis *
Yes No

Anemia *
Yes No

Artificial heart-valve *
Yes No

Bronchitis *
Yes No

Congenial heart lesions *
Yes No

Emphysema *
Yes No

Glandular disorders *
Yes No

Heart disease or attack *
Yes No

Heart rhythm disorder *
Yes No

Hepatitis B *
Yes No

High/Low blood pressure *
Yes No

Hypertension *
Yes No

Liver disease *
Yes No

Mental/nervous disorder *
Yes No

Psychiatric treatment *
Yes No

Sickle cell disease *
Yes No

Stroke *
Yes No

Ulcers *
Yes No

Angina pectoris *
Yes No

Artificial joints (hips, knee) *
Yes No

Cancer *
Yes No

Cortisone / steroid *
Yes No

Epilepsy or seizures *
Yes No

Glaucoma *
Yes No

Heart murmur *
Yes No

Hepatitis C *
Yes No

Hodgkin's disease *
Yes No

Jaundice *
Yes No

Lung disease *
Yes No

Mitral valve prolapse *
Yes No

Radiation treatment/ chemotherapy *
Yes No

Sinus trouble *
Yes No

Thyroid disease *
Yes No

Venereal disease *
Yes No

Other

Has the CHILD PATIENT recently had any of the following

Measles *
Yes No

Indicate the approximate date *

Chicken Pox
Yes No

Indicate the approximate date *

Tonsillitis *
Yes No

Indicate the approximate date *

Mumps *
Yes No

Indicate the approximate date *

Strep throat *
Yes No

Indicate the approximate date *

Women Only

Are you pregnant or suspect you might be? *
Yes No

If yes, what is the expected birth date?

Are you taking any birth control pills? *
Yes No

Describe *

Do you currently have, or have had in the past any disease, condition or problem not listed above? *

Yes No

Describe *

Is there any thing else about your health we should be made aware of? *

Yes No

Describe *

Do you wish to speak to the Doctor privately about any problems or medical condition? *

Yes No

Dental History

Medical Alert

Condition:

Premedication:

Are you experiencing any dental problems? *

Yes No

Describe *

Date of your last dental visit?

Date of your last dental cleaning:

When were X-rays taken last?

Have you been seeing a dentist regularly? *

Yes No

Describe

Are there any growths or sore spots in your mouth? *

Yes No

Describe

Have you noticed any loose teeth? Or have any of your teeth shifted? *

Yes No

Describe *

Does food get caught between your teeth? *

Yes No

Describe *

Are any of your teeth sensitive to heat, cold, sweets or pressure?

Yes No

Describe *

Have you been advised to take antibiotics before a dental appointment? *

Yes No

Describe *

Do you use dental floss, proxabrush, or stimudents? *

Yes No

Describe *

How often? *

How often do you brush your teeth? *

Do you feel that you have bad breath? *

Yes No

Describe *

Have you ever had one of the following?

Periodontal treatment? (treatment of the gums) *
Yes No

Describe *

Orthodontic treatment? (straighten or realign teeth) *
Yes No

Describe *

A bite plate or any other appliance? *
Yes No

Describe *

Your bite adjusted or teeth ground *
Yes No

Describe *

Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) *
Yes No

Describe *

JAW PROBLEMS – do you have any of the following?

Popping / clicking in your jaw joints? *
Yes No

Describe *

Pain in your jaw joints, around your ear, or side of your face?
Yes No

Describe *

Difficulty in opening or closing? *
Yes No

Describe *

Pain when teeth are clenched? *
Yes No

Describe *

Pain / difficulty in chewing? *
Yes No

Describe *

Do you have any of the following habits?

Clenching or grinding your teeth while awake or sleep? *
Yes No

Describe *

Biting your cheeks or lips regularly? *
Yes No

Describe *

Breathing through your mouth while awake or asleep? *
Yes No

Describe

Hold foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)? *
Yes No

Describe *

Do you have any emotional concerns about having dental treatment? *
Yes No

Describe *

Are you happy with the appearance of your teeth? *
Yes No

If not, what would you like to see changed? *

Have you ever had an upsetting experience in a dental office, or any complications during or following dental *

Yes No

Describe *

Name *

Parent's/Guardian's Signature

Date:

Month Day Year