Dr Steve Kozomara B.Sc., B.Dent, M.Sc. Dip Perio, FRCD(C)____PERIODONTICS AND IMPLANT DENTISTRY

MEDICAL HISTORY QUESTIONNAIRE

MR.☐ MRS. ☐ MS. ☐ MISS. ☐ DR. ☐

NAME: _____

DATE OF BIRTH: _____

ADDRESS (HOME): _____

_____

CITY: _____ POSTAL CODE: _____

PHONE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____

EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE:

_____

REASON FOR REFERRAL: _____

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____

DENTAL INSURANCE COMPANY: _____

NAME OF SUBSCRIBER: _____

DATE OF BIRTH: _____

GROUP#: _____ CERTIFICATE#: _____

WHY DID YOU MAKE THIS APPOINTMENT? : _____

WHAT TYPES OF DENTAL TREATMENT HAVE YOU HAD DONE IN THE PAST? : _____

HOW DO YOU CLEAN YOUR TEETH? : _____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH, WHAT WOULD YOU CHANGE? : _____

HOW MUCH DO YOU VALUE YOUR TEETH? : _____

WHAT HAVE YOU BEEN TOLD ABOUT DENTAL IMPLANTS? : _____

WHAT DO YOU ENJOY DOING IN YOUR LEISURE TIME? : _____

DO ANY OF THE FOLLOWING APPLY TO YOU?

	YES	NO		YES	NO
NERVOUS DURING DENTAL TREATMENT	□	□	FOOD WEDGING BETWEEN TEETH	□	□
PAIN IN JAW, FACE, MOUTH	□	□	SHIFTING OF TEETH	□	□
BLEEDING GUMS	□	□	CLENCHING OR GRINDING OF TEETH	□	□
LOOSE TEETH	□	□	PAIN IN EAR	□	□
BAD BREATH/ BAD TASTE	□	□	FREQUENT HEADACHES	□	□
ABSCESSESOR SWELLING	□	□	JAW JOINTS SOUNDS OR PAIN	□	□
SENSITIVE TEETH TO HOT OR COLD	□	□	DIFFICULTY OR PAIN ON OPENING	□	□

1. ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION AT THE PRESENT OR HAVE YOU BEEN TREATED WITHIN THE PAST YEAR?
   _____
   _____

2. WHEN WAS YOUR LAST MEDICAL CHECKUP? : _____
   _____

3. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? : _____
   _____

4. ARE YOU TAKING ANY MEDICATIONS, NON-PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS OF ANY KIND? : _____
   _____

5. DO YOU HAVE ANY ALLERGIES? PLEASE LIST: _____
   _____

6. HAVE YOU EVER HAD A PECULIAR OR ADVERSE REACTION TO ANY MEDICINES OR INJECTIONS? : _____
   _____

7. HAVE YOU EVER BEEN ADVISED BY YOUR DOCTOR TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT? : _____
   _____

8. DO YOU HAVE ANY CONDITIONS OR THERAPIES THAT COULD AFFECT YOUR IMMUNE SYSTEM? :
   IE: LEUKEMIA, AIDS, HIV INFECTION, RADIOTHERALY, CHEMOTHERAPY
   _____
   _____

9. HAVE YOU EVER BEEN HOSPITALIZED FAR ANY ILLNESS OR OPERATIONS? : _____
   _____
   _____

10. DO YOU SMOKE OR CHEW TOBACCO PRODUCTS? : _____

11. FOR WOMEN ONLY: ARE YOU BREASTFEEDING OR PREGNANT? IF PREGNANT WHAT IS THE EXPECTED DELIVERY DATE? : _____

    _____

12. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

□ CHEST PAIN, ANGINA	□ SHORTNESS OF BREATH	□ PACEMAKER	□ STEROID THERAPY
□ SEIZURES (EPILEPSY)	□ DRUG/ALCOHOL DEPENDENCY	□ HEART ATTACK	□ STROKE
□ PROSTHETIC HEART VALVE	□ TUBERCULOSIS	□ STOMACH ULCERS	□ THYROID DISEASE
□ CANCER	□ ARTHRITIS	□ DIET PILL THERAPY	□ ASTHMA
□ HIGH BLOOD PRESSURE	□ HEART MURMUR	□ MITRAL VALVE PROLAPSE	□ RHEUMATIC FEVER
□ PROSTHETIC OR ARTIFICIAL JOINT		□ HEPATITIS, JAUNDICE OR LIVER DISEASE	
□ BLEEDING PROBLEM DISORDER		□ DIABETES	

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT:

PATIENT/ PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____