SUNCOAST DENTAL

Goderich, Ontario · (226) 22SMILE · suncoastdental.ca

MEDICAL HISTORY

Confidential health questionnaire

Your full medical history helps us treat you safely. Please answer every question to the best of your knowledge — if you're not sure, leave blank and we'll review with you at your visit. All information is kept confidential per PHIPA.

PATIENT

FULL NAME _____ DATE OF BIRTH _____

FAMILY DOCTOR _____ DOCTOR PHONE _____

DATE OF LAST PHYSICAL EXAM _____ DATE OF LAST DENTAL VISIT _____

GENERAL HEALTH

HOW WOULD YOU RATE YOUR GENERAL HEALTH?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under a physician's care for any condition? ☐ Yes ☐ No

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No

Have you had any major surgery in the past 5 years? ☐ Yes ☐ No

IF YES TO ANY ABOVE, PLEASE DESCRIBE

_____

_____

_____

MEDICAL CONDITIONS — PLEASE CHECK ANY THAT APPLY

☐ Heart disease	☐ High blood pressure	☐ Heart attack	☐ Stroke
☐ Heart murmur	☐ Pacemaker	☐ Artificial heart valve	☐ Angina
☐ Diabetes (Type 1)	☐ Diabetes (Type 2)	☐ Thyroid disorder	☐ Asthma
☐ Tuberculosis	☐ Emphysema / COPD	☐ Sleep apnea	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ HIV / AIDS	☐ Kidney disease
☐ Liver disease	☐ Cancer (specify below)	☐ Radiation therapy	☐ Chemotherapy
☐ Bleeding disorder	☐ Anemia	☐ Epilepsy / seizures	☐ Stroke / TIA
☐ Arthritis	☐ Osteoporosis	☐ Mental health condition	☐ Eating disorder
☐ Drug or alcohol dependency	☐ Glaucoma	☐ Migraine headaches	☐ Other (specify below)

DETAILS ON ANY CONDITION CHECKED ABOVE (ESPECIALLY CANCER TYPE, CURRENT STATUS)

_____

_____

_____

MEDICATIONS

ALL CURRENT MEDICATIONS — PRESCRIPTION, OVER-THE-COUNTER, AND SUPPLEMENTS (INCLUDE DOSAGE IF KNOWN)

Are you taking blood thinners (e.g. Warfarin, Coumadin, Eliquis, Xarelto, daily Aspirin)? ☐ Yes ☐ No

Are you taking or have you taken bisphosphonates (e.g. Fosamax, Boniva, Actonel, Zometa)? ☐ Yes ☐ No

Have you ever taken steroids (e.g. Prednisone) for more than 2 weeks? ☐ Yes ☐ No

ALLERGIES

DRUG ALLERGIES (PENICILLIN, CODEINE, SULFA, LATEX, ETC.) AND REACTIONS

FOOD, ENVIRONMENTAL, OR MATERIAL ALLERGIES

WOMEN — REPRODUCTIVE HEALTH

Are you currently pregnant? ☐ Yes ☐ No

IF PREGNANT, DUE DATE AND OB/GYN NAME

Are you currently nursing? ☐ Yes ☐ No

Are you taking oral contraceptives or hormone replacement? ☐ Yes ☐ No

LIFESTYLE

TOBACCO USE

☐ Never used ☐ Former user

☐ Current — cigarettes ☐ Current — other (vape, chew)

ALCOHOL USE

☐ None ☐ Occasional (≤1 drink/day)

☐ Moderate (2–3 drinks/day) ☐ Heavy (4+ drinks/day)

DENTAL HISTORY & COMFORT

Have you ever had a bad reaction to dental anesthetic? ☐ Yes ☐ No

Have you ever required sedation for dental work? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have jaw pain, popping, or limited opening (TMJ symptoms)? ☐ Yes ☐ No

HOW DO YOU FEEL ABOUT DENTAL VISITS?

☐ Comfortable ☐ Mild anxiety ☐ Moderate anxiety ☐ Severe phobia

ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL OR DENTAL HISTORY?

ACKNOWLEDGEMENT

I confirm the information provided is accurate and complete to the best of my knowledge. I understand that withholding information could affect my treatment and that I am responsible for notifying Suncoast Dental of any changes to my health or medications at future appointments.

SIGNATURE

DATE