Pawliuk
FAMILY DENTISTRY

HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ Date Year/Month/Day _____

Date of Birth Year/Month/Day _____

Address _____ City _____

Postal Code _____

Phone Number (check which is preferred)

- ☐ Home _____
- ☐ Work _____
- ☐ Cell _____

Email _____

For appointment reminders which do you prefer? ☐ Text ☐ Email ☐ Phone Call

Primary Physician:

Name_____ Phone #_____
Address _____ City _____
Postal Code _____

Name of Medical Specialist and their specialty:_____
Phone #_____
Address _____ City _____
Postal Code _____

Emergency Contact: _____ Relationship: _____
Phone #(home)_____ Phone #(cell)_____

Person responsible for account: _____
Dental Insurance: ☐ Yes ☐ No
Name of Insurance Company_____
Group Policy Number_____
Cert/ID Number_____

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

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

2. Has there been any change in your general health in the past year?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

3. When was your last medical checkup?

_____

4. Do you have any conditions that could affect your immune system e.g. leukemia, HIV infection +/- tested, lupus?

☐ Yes ☐ No ☐ Not Sure

5. Are you undergoing any therapies that could affect your immune system e.g. radiotherapy or chemotherapy?

☐ Yes ☐ No ☐ Not Sure

6. Are you currently taking any steroids or cortisone?

☐ Yes ☐ No ☐ Not Sure

7. Do your ankles, feet or hands swell?

☐ Yes ☐ No ☐ Not Sure

8. Are you allergic to any medications?

☐ Yes ☐ No ☐ Not Sure

List medications:

_____

_____

9. Are you allergic to any of the following:

☐ Latex
☐ Rubber
☐ Metal
☐ No
☐ Not Sure

10. Are you allergic to any foods?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

11. Do you have any other allergies that we should be aware of?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

12. Have you ever had any peculiar or adverse reactions to any medicines or injections?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

13. Are you taking or have you ever taken osteoporosis medications (e.g. Fosamax, Actonel)?

☐ I am currently taking
☐ I was previously taking but am no longer
☐ No
☐ Not Sure

14. Are you currently taking any prescription medications?

☐ Yes
☐ Yes and I brought a list
☐ No
☐ Not Sure

Provide details:

_____

_____

_____

15. Have you been advised against taking any medications?

☐ Yes ☐ No ☐ Not Sure

Provide details:

_____

_____

16. Are you taking any non-prescription drugs?

☐ Yes
☐ Yes and I brought a list
☐ No
☐ Not Sure

Provide details including frequency:

_____

_____

17. Do you take any recreational drugs on a regular basis?

☐ Yes ☐ No ☐ Not Sure

Provide details including frequency:

_____

_____

18. Are you taking any herbal supplements of any kind?

☐ Yes
☐ Yes and I brought a list
☐ No
☐ Not Sure

Provide details including frequency:

_____

_____

19. Do you have Diabetes?

- ☐ I have Type 1 Diabetes
- ☐ I have Type 2 Diabetes
- ☐ No
- ☐ Not Sure

If so - How is it controlled?

- ☐ Diet
- ☐ Medication

20. Do you have or have you ever had any of the following?

- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Cancer
- ☐ Chest pain, angina
- ☐ Crohn's
- ☐ Drug/alcohol dependency
- ☐ Fainting or dizzy spells
- ☐ Glaucoma
- ☐ Head/neck injuries
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease/Emphysema
- ☐ Malignant hyperthermia
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic/Scarlet fever
- ☐ Seizures (Epilepsy)
- ☐ Shortness of breath
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Psychiatric/mental disorders
- ☐ Hay Fever
- ☐ Joint Replacement
- ☐ None of the above

21. Do you have a history of any immuno-compromising disease or condition?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

22. Do you have or have you had any conditions or diseases not previously listed that we should be aware of?

☐ Yes ☐ No ☐ Not Sure

Please explain:

_____

_____

23. Are there any diseases or medical problems that run in your family?

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Malignant Hyperthermia
- ☐ Other
- ☐ Not sure
- ☐ No

Please explain:

_____

_____

24. Do you have a bleeding problem or bleeding disorder?

☐ Yes ☐ No ☐ Not Sure

25. Do you have or have you ever had a replacement or repair of a heart valve or stent?	☐ Yes ☐ No ☐ Not Sure
26. Do you have or have you ever had an infection of the heart (e.g. infective endocarditis)?	☐ Yes ☐ No ☐ Not Sure
27. Have you had a transplant (heart, lungs, organs)?	☐ Yes ☐ No ☐ Not Sure
28. Do you have a heart condition from birth (e.g. congenital heart disease/lesions)?	☐ Yes ☐ No ☐ Not Sure
29. Do you have or have you ever had any heart or blood pressure problems?	☐ Yes ☐ No ☐ Not Sure
30. Do you have a prosthetic or artificial joint?	☐ Yes ☐ No ☐ Not Sure
31. Have you ever been hospitalized for any illnesses or operations?	☐ Yes ☐ No ☐ Not Sure Please explain: _____ _____
32. Have you ever had any injury or surgery to your face or jaws?	☐ Yes ☐ No ☐ Not Sure
33. Do you smoke or chew tobacco products?	☐ Yes ☐ No ☐ Not Sure
34. Are you nervous during dental treatment?	☐ Yes ☐ No ☐ Not Sure
35. Is there anything else about your health we should be made aware of?	☐ Yes ☐ No ☐ Not Sure Please explain: _____ _____
36. Do you wish to speak to the doctor privately about any problem or medical condition?	☐ Yes ☐ No ☐ Not Sure
37. Has the child patient recently had any of the following?	☐ Chicken pox ☐ Measles ☐ Mumps ☐ Strep throat ☐ Tonsilitis ☐ None of the above/Not applicable
38. Are there any immunizations that the child is not up to date with?	☐ Yes ☐ No / Not Applicable ☐ Not Sure
39. For women only: Are you breastfeeding?	☐ Yes ☐ No / Not Applicable
40. For women only: Are you pregnant?	☐ Yes ☐ No / Not Applicable ☐ Not Sure What is your expected delivery date? _____

Pawliuk
FAMILY DENTISTRY

DENTAL HISTORY QUESTIONNAIRE

Are you experiencing any dental problems? ☐ Yes ☐ No

Date of your last Dental Visit: _____
Dental Cleaning: _____
When were X-rays taken last? _____

1. Have you been seeing a dentist regularly? ☐ Yes ☐ No
2. Are there any growths or sore spots in your mouth? ☐ Yes ☐ No
3. Have you noticed any loose teeth, or have any of your teeth shifted? ☐ Yes ☐ No
4. Does food get caught between your teeth? ☐ Yes ☐ No
5. Are any of your teeth sensitive to heat, cold, sweets or pressure? ☐ Yes ☐ No
6. Have you been advised to take antibiotics before a dental appointment? ☐ Yes ☐ No
7. Do you use dental floss, proxabrush, or stimudents? ☐ Yes ☐ No

   If yes, how often? _____
8. How often do you brush your teeth? _____

   Do you feel that you have bad breath? ☐ Yes ☐ No
9. Have you ever had one of the following?
   - Periodontal treatment? *(treatment of the gums)* ☐ Yes ☐ No
   - Orthodontic treatment? *(to straighten or realign teeth)* ☐ Yes ☐ No
   - A bite plate or any other appliance? ☐ Yes ☐ No
   - Your bite adjusted or teeth ground? ☐ Yes ☐ No
   - Oral surgery? *(surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)* ☐ Yes ☐ No
10. JAW PROBLEMS - Do you have any of the following?
    - Popping/clicking in your jaw joints? ☐ Yes ☐ No
    - Pain in your jaw joints, around your ear, or side of your face? ☐ Yes ☐ No
    - Difficulty in opening or closing? ☐ Yes ☐ No
    - Pain when teeth are clenched? ☐ Yes ☐ No
    - Pain/difficulty in chewing? ☐ Yes ☐ No
11. Do you have any of the following habits?
    - Clenching or grinding your teeth while awake or asleep? ☐ Yes ☐ No
    - Biting your cheeks or lips regularly? ☐ Yes ☐ No
    - Breathing through your mouth while awake or asleep? ☐ Yes ☐ No
    - Hold foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)? ☐ Yes ☐ No

12. Do you have any emotional concerns about having dental treatment? ☐ Yes ☐ No

13. Are you happy with the appearance of your teeth? ☐ Yes ☐ No

If no, what would you like to see changed? _____

14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns? ☐ Yes ☐ No

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General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to preform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Print Name of Guardian _____

Signature ☐ Patient ☐ Parent ☐ Guardian _____

Reviewed by Treating Dentist _____

Date _____