FUNDY DENTAL CENTRE

OFFICE USE ONLY - DO NOT FILL IN THIS AREA

Today's Date: DD _____/ MM _____/ YEAR _____

Patient's Legal Name: _____ Age: _____

Patient's Preferred Name: _____ *(if different than legal)*

Gender (circle): M / F / Other ASA Score: _____ Height: _____ Weight: _____ = BMI: _____

Current Meds: _____

Med Hx. Summary: _____

_____

Allergies to Medications: _____

MEDICAL HISTORY QUESTIONAIRE:

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. **Please fill in the entire form.**

Today's Date: DD _____/ MM _____/ YEAR _____

Patient Name: _____ Gender (circle): M / F / Other

Patient's Preferred Name: _____ *(if different than legal)*

Date of Birth: DD _____/ MM _____/ YEAR _____ Age: _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

Emergency Contact Person: _____

Relationship to You: _____ Their Phone: (_____)_____-_____

If applicable, name of parent or legally authorized representative: _____

Family Doctor/Practitioner: _____ Phone: (_____)_____-_____

Medical Specialist *(if applicable)*: _____ Phone: (_____)_____-_____

Pharmacy: _____ Phone: (_____)_____-_____

Your Measurements: Height: _____ Weight: _____

FUNDY DENTAL CENTRE

1. Have you ever had minimal or moderate sedation? Yes: ☐ No: ☐
   - What types: _____
   - Any complications? Yes: ☐ No: ☐

     If yes, explain: _____
2. When was your last medical check-up? _____
3. Are you being treated for any medical conditions currently, or within the past year? Yes: ☐ No: ☐

   If yes, please explain: _____
4. Has there been any change in your general health in the past year? Yes: ☐ No: ☐

   If yes, please explain: _____
5. **FEMALE PATIENT:** Currently Pregnant: Yes: ☐ No: ☐ Breast-feeding: Yes: ☐ No: ☐
6. Taking any medications, inhalers, non-prescription drugs, or herbal supplements? Yes: ☐ No: ☐

   If yes, please list below *or* provide a printed list to our staff:
   - _____ _____
   - _____ _____
   - _____ _____
   - _____ _____
7. Do you have any allergies? Yes: ☐ No: ☐

   If yes, please list below:
   - Medications: _____
   - Latex/rubber products: _____
   - Other (seasonal, foods, etc.): _____
8. Do you have breathing/lung issues: Yes: ☐ No: ☐

   Asthma / COPD / Sleep Apnea / Snoring / *other:* _____ *(Please circle all that apply.)*

   If yes, please complete the following:
   - How often do you use an inhaler? _____
   - Do you use a CPAP machine? Yes: ☐ No: ☐
   - Have you ever been hospitalized for these issues? Yes: ☐ No: ☐
9. Do you use narcotics or sedatives on a regular basis? Yes: ☐ No: ☐
10. Have you ever had any heart-related issues, examples: replacement/repair of a heart valve, an infection of the heart, stents or devices placed, a condition from birth, or a heart transplant? Yes: ☐ No: ☐

    If yes, please explain below: _____

11. Do you have, or have you ever had experience with any of the following? *(Please circle all that apply.)*

Diabetes (Type: _____)	Heart attack (Date: _____)	Stroke (Date: _____)	
Chest pain/Angina	Mitral Valve Prolapse	Stents	Pacemaker
Heart Murmur	AFIB	High Blood Pressure	Low Blood Pressure
Lung Disease	Asthma	Sleep Apnea	COPD
Stomach Ulcers	Thyroid Disease	Rheumatic Fever	Tuberculosis
Radiation / Chemo	Steroid therapy	ADD / ADHD	Autism / Aspergers
Anxiety	Depression	PTSD	Migraines
Dementia / Alzheimer's	Vision-Impaired	Hearing-Impaired	Physical Limitations
Smoke / Vape	Drug Addiction	Alcohol Addiction	Addiction Treatment
Prosth. / Artificial Joint	Chronic Pain	Arthritis / Osteoporosis	Fibromyalgia
Hepatitis	Jaundice	Liver Disease	Kidney Disease
STDs	HIV	AIDS	Infectious Disease *(other)*

Immunocompromised (Explain: _____)

Bleeding Problems/Disorders (Explain: _____)

Seizures (Explain: _____)

Cancer (Type: _____ / Current Status: _____)

Psychiatric Disorders (Explain: _____)

- Are there any conditions or diseases not listed that you have or ever had? Yes: ☐ No: ☐
  - If yes, please list: _____

>> NOTE: YOU ARE RESPONSIBLE TO NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR HEALTH BEFORE TREATMENT! <<

I, the undersigned or legal guardian/representative, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

I also consent to the physician and/or pharmacy I listed being contacted to obtain any information that is required for dental treatment.

Patient/Representative (print): _____

Patient/ Representative (signature): _____ Date: _____

Form completed by: Patient: ☐ Parent: ☐ Legally Authorized Representative: ☐