KÜMEÜ DENTAL

love your smile!

Medical & Dental History Questionnaire

BEFORE YOUR APPOINTMENT (Please Print)

Title: Full Name: _____

Date of Birth (day/month/year): _____

Home Address: _____

City: _____ Postal Code: _____

Home Phone: _____

Mobile Phone: _____

Business Phone: _____

Email: _____

Preferred method of contact: Email ◯ Text ◯

Occupation: _____

How did you hear about us? _____

Next of Kin: _____ Phone: _____

Relationship: _____

MEDICAL HISTORY: 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.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

Yes No Not Sure _____

2. Has there been any change in your general health in the past year? If yes, please explain.

Yes No Not Sure/ Maybe _____

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

Yes No Not Sure/Maybe _____

Bisphosphonate medications such as Fosomax & Actonel _____

4. Do you have any allergies? Yes No Not Sure/Maybe

If yes, please list using the categories below:

a) Medications (e.g penicillin) _____

b) latex/rubber products _____

c) other (e.g. hayfever, foods) _____

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes No Not Sure

If yes, please explain _____

6. Do you have or have you ever had asthma? Yes No Not Sure/Maybe

7. Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure/Maybe

8. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

Yes No Not Sure/Maybe

9. Do you have a prosthetic or artificial joint? Yes No Not Sure/Maybe

10. Do you have any conditions or therapies that could affect your immune system, Please circle (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? Yes No Not Sure/Maybe

11. Have you ever had hepatitis, jaundice (other than at birth) or liver disease? Yes No Not Sure/Maybe

Please circle

OVER >>

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

Yes No Not Sure/Maybe _____

14. Have you ever been hospitalized for any illnesses or operations recently? If yes, please explain.

Yes No Not Sure/Maybe _____

15. Do you have or have you ever had any of the following? Please circle.

- o Chest pain, Angina
- o Heart attack
- o Stroke
- o Shortness of breath
- o Rheumatic fever
- o Mitral valve
- o Prolapse
- o Heart murmur
- o Pacemaker
- o Lung disease
- o Tuberculosis
- o Cancer
- o Steroid therapy
- o Diabetes
- o Stomach ulcers
- o Arthritis
- o Seizures
- o Kidney disease
- o Thyroid disease
- o Organ transplant
- o Drug/alcohol dependency
- o Osteoporosis medications (e.g.Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?

Yes No Not Sure/Maybe _____

17. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease)

Yes No Not Sure/Maybe _____

18. Do you smoke or chew tobacco products?

Yes No Not Sure/Maybe How many per day?_____ Number of years?_____

FOR WOMEN ONLY

1. Are you pregnant? Yes No Not Sure/Maybe Expected delivery date? _____

2. Are you breastfeeding? Yes No

3. Are you taking birth control medication Yes No

DENTAL HISTORY

1. Last dental visit?_____ **2.** What was done at that visit? _____

3. How frequently do you see your dentist? _____

4. Have you ever had a full mouth series of X-rays (16 or more x-rays taken at the same time) Yes No

If yes approximately when? _____

5. How would you describe your dental health at present Good Fair Poor

6. What are your present dental concerns, if any?

Bleeding gums Crooked teeth Cosmetic Loose teeth Bad Breath
Food Trapping Toothache Loose dentures Missing teeth/spaces Other _____

7. What could make you smile more confidently?

Whiter/brighter teeth Straighter teeth Nicer shape of teeth Other _____

8. Have you had any teeth extracted due to accident, decay or gumdisease? Yes No

If yes, please explain_____

9. If yes, have you had any complications after the extraction? Yes No

10. Have you been taught PREVENTIVE ORAL HYGIENE? Yes No

11. Are you anxious during dental visits? Yes No

12. Do you think you might like to have your dental treatment done while you are sedated? Yes No

I have read and accepted the following conditions:
*The medical history I have given is true and correct to my knowledge
*Payment is to be made on the day of treatment
*In the event that you should need to change or cancel your appointment, we request that you inform us at least 48 hours before your appointment time or you may be charged a cancellation fee.

X _____ _____

SIGNATURE, PARENT OR GUARDIAN IF UNDER 18 DATE