Medical and Dental History

❑ Ms. ❑ Mr. **FAMILY NAME :** **First Name :**

Date of birth : __ __/ __ __/ __ __ __ __ Social Security Number : __/__ __/__ __/__ __/__ __ __/__ __ __/__ __

Have you ever had any of the following disease ?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Thyroid trouble	❑	❑	Glaucoma	❑	❑
Hormonal disorder	❑	❑	Oral herpes	❑	❑	Heart attack	❑	❑
Breathing problems	❑	❑	Cardiac disease	❑	❑	Liver disease	❑	❑
Depression – nervous problem	❑	❑	Blood disease	❑	❑	Sinus trouble	❑	❑
Skeletal/bone/joints disorder	❑	❑	Venereal disease	❑	❑	Blackout	❑	❑
Congenital heart disorder	❑	❑	Oedema (swelling)	❑	❑	Osteoporosis	❑	❑
Hepatitis (select :) A, B or C	❑	❑	Fainting or dizziness	❑	❑	Tuberculosis	❑	❑
Immunological disease (HIV…)	❑	❑	Circulatory problems	❑	❑	Cancer	❑	❑
Ulcers, stomach/intestinal disease	❑	❑	Lung disease	❑	❑	Asthma	❑	❑
Coagulation/bleeding disorder	❑	❑	Rheumatic fever	❑	❑	Diabetes	❑	❑
Epilepsy, seizure	❑	❑	Kidney disease	❑	❑	Stroke	❑	❑
ENT (Ear, Nose & Throat) problem	❑	❑	Dermatological issues	❑	❑	Postural disorder	❑	❑

❑ Other illness (specify) :

Are you currently taking medicine of any kind ?

	Yes	No		Yes	No		Yes	No
Antibiotic	❑	❑	Tranquillizers	❑	❑	Anticoagulants (blood thinner)	❑	❑
Antihistamines	❑	❑	Anti-inflammatory	❑	❑	Osteoporosis medication	❑	❑
Antidepressant	❑	❑	Insulin	❑	❑	Blood pressure medication	❑	❑
Sleeping pills	❑	❑	Aspirin	❑	❑	Oral contraceptive	❑	❑

❑ Other medication (specify) :

Have you undergone in the past any of the following medical treatment ?

	Yes	No		Yes	No		Yes	No
Transplant	❑	❑	Radiation treatment	❑	❑	Growth hormones	❑	❑
Blood transfusion	❑	❑	Chemotherapy	❑	❑	Prosthesis (other than dental)	❑	❑
Dialysis	❑	❑	Artificial heart valve	❑	❑	Hospitalization and/or surgery	❑	❑

Are you taking or have you EVER take **bisphosphonates drugs** ? Yes ❑ No ❑

(Examples of Bisphosphonates drugs : Didronel®, Actonel®, Fosamax®, Lytos®, Arédia®, Skelid®, Zometa®…)

❑ Other (specify) :

Do you suffer from any allergy ?

	Yes	No		Yes	No		Yes	No
Nickel	❑	❑	Penicillin	❑	❑	Aspirin	❑	❑
Other Metal	❑	❑	Other antibiotic	❑	❑	Dust mite	❑	❑
Latex / rubber	❑	❑	Anti-inflammatory	❑	❑	Seasonal allergies	❑	❑
Iodine and derivatives	❑	❑	Barbiturates (sleeping pills)	❑	❑	Cleaning products	❑	❑
Local Anesthesics	❑	❑	Codeine	❑	❑	Food Allergy	❑	❑

❑ Other drugs (specify) :

DON'T FORGET TO TURN THE PAGE

Additional Informations

Are you under the care of a physician ? Yes ❑ No ❑ His name : ________________________________

Do you know your usual blood pressure ? Yes ❑ No ❑ Specify : ________________________________

Are you on special diet ? Yes ❑ No ❑ Specify : ________________________________

Do you have trouble sleeping ? Yes ❑ No ❑

Do you bleed excessively when cut ? Bruise easely ? Yes ❑ No ❑

Do you smoke ? Yes ❑ No ❑

If so, what kind of tobacco (cigarettes, cigars, pipe…) ? ________________________________

What is your daily consumption ? ________________________________

If not, have you *ever* smoked ? Yes ❑ No ❑ When did you stop ? ________________________________

Are you currently pregnant ? Yes ❑ No ❑

- If so, for how many month ? ____________________
- If not, are you currently trying to get pregnant ? Yes ❑ No ❑

Are your currently breast feeding ? Yes ❑ No ❑

About your Teeth

Reason for today's visit : --------------------------------

When was your last dental check up ? --------------------------------

During your previous appointments, have you had problems or difficulties of any kind ? Yes ❑ No ❑

- if so, what happened ? --------------------------------

Have you ever had any trouble during or after a tooth extraction or an oral surgery ? Yes ❑ No ❑

Have you ever had any complication following an oral anesthetic or a dental procedure ? Yes ❑ No ❑

Do you suffer from any toothache, pain in your mouth, temporomandibular joints or in your gums ? Yes ❑ No ❑

Do you have bleeding Gums ? Yes ❑ No ❑ When ? ❑ When brushing ❑ Upon chewing ❑ Spontaneously

Do you have trouble eating or chewing ? Yes ❑ No ❑

Are you pleased with the appearence of your teeth ? Yes ❑ No ❑

What is your main concern regarding your teeth and your smile ?

Do you have any fear of having dentistry done ? ❑ Not at all ❑ A little ❑ Moderately ❑ very much

Feel free to add any comment that you think useful or important :

« To the best of my knowledge, the questions on this form have been correctly answered. I understand that providing incorrect informations can be dangerous to my health. It is my responsibility to inform the dental office of any change in my medical status. »

City : Date : <u>PATIENT'S SIGNATURE :</u>