Access Dental Care

Patient Name: _____ **Date:** _____

YES NO ?

1. Has there been any change in your general health in the past year? ……..…… ❑❑❑
   Explain: _____
2. Are you being treated for any medical condition at present or within the past two years?..... ❑❑❑
   Explain_____
3. Are you presently under the care of a physician? Date of last medical check-up: _____ ❑❑❑
4. Have you ever had a serious illness requiring hospitalization or extensive medical care?..... ❑❑❑
   Explain:_____
5. Are you taking any prescription, non-prescription, or herbal medications of any kind? If yes, please list: ..… ❑❑❑

1. _____	Reason:_____		6. _____	Reason:_____	
2. _____	Reason:_____		7. _____	Reason:_____	
3. _____	Reason:_____		8. _____	Reason:_____	
4. _____	Reason:_____		9. _____	Reason:_____	
5. _____	Reason:_____		10. _____	Reason:_____	

6. Do you have any allergies? (e.g. medications, latex, rubber, hay fever, foods, metals) …… ❑❑❑
   Explain:_____
7. Have you ever had a peculiar or adverse reaction to any medications or injections (e.g. penicillin or other antibiotics, aspirin, local anaesthetic (dental freezing), codeine, nitrous oxide, chlorohexidine (Peridex), or any other medicine)? Explain: _____ ❑❑❑
8. Do any allergic reactions result in headache, swelling, shortness of breath, chest constriction or nausea?.... ❑❑❑
   Specify:_____
9. Please check off all the following conditions you presently have, or have had. (If not sure, check "?")

Y N ?	Y N ?	Y N ?
❑❑❑ any heart problem	❑❑❑ swelling of feet/ankles/hands	❑❑❑ artificial joint/hip/knee
❑❑❑ infection of the heart (endocarditis)	❑❑❑ anemia/blood disorders	❑❑❑ arthritis/rheumatism
❑❑❑ artificial heart valve	❑❑❑ scarlet fever/rheumatic fever	❑❑❑ seizures or epilepsy
❑❑❑ heart murmur	❑❑❑ hepatitis A, B, C	❑❑❑ kidney disease
❑❑❑ mitral valve prolapse	❑❑❑ jaundice	❑❑❑ cancer
❑❑❑ high blood pressure	❑❑❑ liver disease	❑❑❑ chemotherapy/radiation
❑❑❑ low blood pressure	❑❑❑ any lung disease	❑❑❑ malignant hyperthermia
❑❑❑ chest pain	❑❑❑ tuberculosis	❑❑❑ hemophilia
❑❑❑ organ transplant/medical implant	❑❑❑ asthma	❑❑❑ glaucoma/vision problems
❑❑❑ angina	❑❑❑ emphysema	❑❑❑ hearing difficulties
❑❑❑ heart surgery	❑❑❑ bronchitis	❑❑❑ glandular disorders
❑❑❑ heart pacemaker	❑❑❑ sinus trouble	❑❑❑ thyroid disease
❑❑❑ heart attack/cardiac arrest	❑❑❑ steroid/cortisone therapy	❑❑❑ herpes/cold sores
❑❑❑ stroke	❑❑❑ diabetes	❑❑❑ sexually transmitted disease
❑❑❑ heart failure	❑❑❑ hypoglycemia	❑❑❑ psychiatric care
❑❑❑ shortness of breath	❑❑❑ stomach/intestinal problems	❑❑❑ mental/nervous disorders
❑❑❑ fainting or dizziness	❑❑❑ bone strengthening pills	❑❑❑ drug/alcohol addiction →
❑❑❑ congenital heart disease/lesion (from birth or early childhood)	(e.g. fosomax, actonel) type_____ how long____	if yes, have you received treatment? Yes ❑ No ❑

MEDICAL HISTORY

YES NO ?

10. Do you have any condition that could affect your immune system?..... ❑ ❑ ❑
    ❑ leukaemia ❑ AIDS ❑ HIV infection ❑ other _____
11. Do you bruise easily or bleed excessively from a cut or injury? …… ❑ ❑ ❑
12. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease).... ❑ ❑ ❑
13. When walking or climbing stairs, do you ever have to stop due to shortness of breath or chest constriction? ..... ❑ ❑ ❑
14. Do you or did you smoke or use any other form of tobacco? If so how much? _____ How long?_____ ❑ ❑ ❑
15. Do you drink alcoholic beverages on a regular basis?..... ❑ ❑ ❑
16. Do you have any mobility concerns (i.e. wheelchair, bedbound, etc)? ..... ❑ ❑ ❑
17. Is there any condition or disease not previously listed that you have or have had? Explain: _____ ❑ ❑ ❑
18. WOMAN ONLY: Are you pregnant? **Y** ❑ **N** ❑ Due Date: _____ Are you nursing? **Y** ❑ **N** ❑
    Are you taking fertility drugs? **Y** ❑ **N** ❑ Are you taking birth control pills? **Y** ❑ **N** ❑
19. CHILD PATIENT ONLY: Have you recently had any of the following (indicate approximate date):
    ❑ measles _____ ❑ mumps _____ ❑ chicken pox _____ ❑ strep throat _____ ❑ tonsillitis _____

Dental History

1. DATE OF YOUR LAST DENTAL VISIT: _____ LAST DENTAL CLEANING: _____ LAST X-RAYS: _____

Y N

2. Are you suffering from any dental pain now? ..... ❑ ❑
3. Do you have any loose teeth?..... ❑ ❑
4. Does food get caught between your teeth?..... ❑ ❑
   If yes, where? _____
5. Do you have any pain in your teeth due to:
   ❑ hot ❑ cold ❑ chewing ❑ pressure ❑ sweet
6. Do your gums ❑ bleed ❑ feel tender ❑ swollen?
   If yes, when? _____ Where? _____
7. Are you aware of sores/growths in your mouth? .. ❑ ❑
8. Do you experience a dry mouth?..... ❑ ❑
9. Do you have a bad taste in your mouth?..... ❑ ❑
10. Do you feel you have bad breath?..... ❑ ❑
11. Do you use any other dental aids/mouth rinses?... ❑ ❑
    If yes, list: _____
12. Do you clench or grind your teeth? …… ❑ ❑
13. Do you use dental floss? How often_____ ❑ ❑
14. How often do you brush your teeth? _____
15. Do you experience jaw/TMJ:
    ❑ pain ❑ popping ❑ clicking
16. Have you had:
    ❑ periodontal treatment (gum surgery)
    ❑ orthodontic treatment (braces)
    ❑ oral surgery ❑ dental implants
    ❑ facial injury ❑ x-ray therapy to face/jaws
17. Is there anything you would like to improve about your smile? **Y** ❑ **N** ❑ If yes, what? _____
18. Have you ever been advised to take antibiotics before a dental appointment? …….…... **Y** ❑ **N** ❑
19. Are you nervous during dental treatment?..... **Y** ❑ **N** ❑
    Indicate your comfort level on the scale below:
    NOT AT ALL—1—2—3—4—5—VERY ANXIOUS

GENERAL RELEASE/CONSENT

I certify that that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the opportunity to ask questions and receive answers regarding this medical/dental history. Should there be any changes in either my health or any other information I have provided, I will advise this dental practice. As may be required, I consent to my physician(s) being contacted regarding any specific medical question. I authorize the Registered Dental Hygienist/Dentist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of care. I understand that I am financially responsible to the Registered Dental Hygienist/Dentist for the dental services provided even if my insurance coverage may not be all inclusive.

❑ **Patient** ❑ **Parent** ❑ **Guardian** ❑ **Other:** _____ **Signature:** _____ **Date:**_____

Registered Dental Hygienist Signature: _____ **Date:**_____

DENTAL HISTORY