

DUNDAS

HERITAGE
 DENTISTRY

LEGACY | INNOVATION | COMFORT

6 Sydenham Street | Dundas ON L9H 2T4 | 905-628-6541 | dundas@drchalicedentist.ca
 dundasheritagedentistry.com

MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

GENERAL HEALTH (please check): **EXCELLENT** **GOOD** **POOR**

DO YOU TAKE ANY MEDICATIONS? **YES** **NO**

If yes, please list medication name, dosage and what you are taking it for.

Include any vitamins or supplements.

Please provide a list from your pharmacy if you are unsure.

Name of Medication	Dosage	Taking for
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

DO YOU HAVE ANY FOOD OR DRUG ALLERGIES? **YES** **NO**

If yes, please list them here: _____

HAVE YOU BEEN DIAGNOSED WITH ANY MEDICAL CONDITIONS? PLEASE LIST:



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MEDICAL QUESTIONNAIRE

DO YOU OR HAVE YOU HAD A HISTORY OF:

	Yes	No		Yes	No		Yes	No
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>			Type? _____		
Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/>		
Year: _____			Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
MVP or Heart Murmur...	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/>		
Congenital Heart Lesion.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Drug/ Alcohol Dependency.	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/ Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
						GERD.....	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU SUBJECT TO PROLONGUED BLEEDING? YES NO

DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST? YES NO

(WOMEN) ARE YOU PREGNANT OR BREASTFEEDING? YES NO

DO YOU HAVE ANY ARTIFICIAL JOINTS? YES NO

HAVE YOU HAD A REPLACEMENT/REPAIR OF A HEART VALVE? YES NO

HAS YOUR DOCTOR ADVISED YOU TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?
 REASON? _____ YES NO

DO YOU TAKE PROLIA, ACTONEL or FOSAMAX? YES NO

DO YOU HAVE A PACEMAKER? YES NO

DO YOU SMOKE (CIGARETTES/ CANNABIS)? YES NO

I affirm the above information is accurate to the best of my knowledge and authorize the dental office to perform dental services that I may need. The dental staff is not responsible for any errors that occur from this form being filled out incorrectly.

PATIENT SIGNATURE: _____ **DATE:** _____

