1-1940 Bank Street, Ottawa, ON K1V 7Z8
P (613) 521-3939 | E info@shifadentistry.com

Medical and Dental Questionnaire

Mr./Miss./Mrs./Dr. Emergency Contact:_____

Name:_____ Relationship:_____

Address (Home):_____ Day-Time Phone:_____

_____ Family Doctor:_____

Date of Birth:_____ Phone: _____

Phone (Home):_____Work:_____Ext:_____Cell:_____

Name and Specialty of Medical Specialist:_____

Phone or Address:_____

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. The dentist will review the questions and explains anything that you do not understand. Please fill in the entire form.

- 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
- When was your last medical checkup? _____
- Have there been any changes in your general health in the past year? If yes, please explain _____ Yes No Not Sure
- Are you taking any medication, non-prescriptions or herbal supplements? Yes No Not Sure

_____

- Do you have any allergies? If yes please list. Yes No Not Sure
  a) Medications_____ b) Latex/rubber_____ c) Other _____
- Have you ever had a peculiar or adverse reaction to any medication or injection? If yes, explain._____
- Do you have or ever had asthma? Yes No Not Sure
- Do you have or ever had any heart or blood pressure problems? Yes No Not Sure
- Do you have or ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes No Not Sure
- Do you have a prosthetic joint or artificial joint? Yes No Not Sure
- Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes No Not Sure.
- Do you have and condition or therapies that could affect your immune system? E.g. Leukemia, AIDS, HIV, radiotherapy, chemotherapy? Yes No Not Sure
- Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure

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- Do you have a bleeding problem or bleeding disorder? Yes No Not Sure

- Have you ever been hospitalized for any illness or operation? If yes, please explain.
  _____ Yes No Not Sure

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

chest pain	shortness of breath	pacemaker	steroid therapy
strokes	drug/alcohol dependent	heart attack	seizures (epilepsy)
lung disease	diabetes	kidney disease	prosthetic heart valve
tuberculosis	stomach ulcers	thyroid disease	cancer
arthritis	diet pill therapy		

- Are there any conditions or disease not listed above that you have or ever had? If so, what?

_____ Yes No Not Sure

- Are there any diseases or medical problems that run in your family? E.g. Diabetes, cancer, heart disease _____ Yes No Not Sure
- Do you smoke or chew tobacco? Yes No Not Sure
- Are you nervous during dental treatment? Yes No Not Sure
- For women only: Are you breast feeding or pregnant? If pregnant, what is the expected delivery date? _____
- When was your last dental visit? _____
- When did you last have dental x-rays? _____
- How often do you brush your teeth? _____ How often do you floss your teeth? _____
- Have you been seeing a dentist regularly? Yes No Not Sure
- Do your teeth ache, or do you have pain when you chew? Yes No Not Sure
- Do your gums bleed when you brush? Yes No Not Sure
- Do you feel that you have bad breath? Yes No Not Sure
- Have you been in an accident that involved blows to your jaw? Yes No Not Sure
- Have you ever had implant surgery in your jaw or jaw joints? Yes No Not Sure
- Are you being followed-up by a dental specialist? Yes No Not Sure
- Is there anything you would like to change about your teeth or your smile?
  _____
- Pleas list anything else not mentioned regarding your dental history.
  _____

To the best of my knowledge, the above information is correct.

Patient/Parent Signature_____ Date: _____

Dentist Signature _____ Date: _____