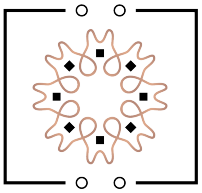
MISSISSAUGA ORTHODONTICS



SIX POINTS ORTHODONTICS

MEDICAL & DENTAL HISTORY QUESTIONNAIRE

Patient Information

Patient name (Mr./Miss/Ms./Mrs./Dr.)

Sex ○ Male ○ Female Date of birth (day/month/year)

Address

Occupation

City Postal code

Name of dentist

Home phone Work phone

Who referred you to our office?

Cell Other

Name of family doctor

Email

In case of emergency, we should notify Relationship

Parent/Guardian Information (if applicable)

Mother's name

Father's name

Address if different from patient

Address if different from patient

City Postal code

City Postal code

Mother's work number Cell

Father's work number Cell

Who will be bringing the patient for the appointment?

Responsible party

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 doctor will review the questions and explain any that you do not understand. Please complete the entire form.

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 / maybe

2 When was your last medical checkup?

3 Has there been any change in your general health in the past year? If yes, please explain.
○ Yes ○ No ○ Not sure / maybe

4 Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
○ Yes ○ No ○ Not sure / maybe

5 Do you have any allergies?
If you answered yes, please list using the categories below:
A Medications B Latex/rubber products
C Other (e.g. hayfever, foods) D Metal/nickel

6 Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
○ Yes ○ No ○ Not sure / maybe

7 Do you have or have you ever had asthma?
○ Yes ○ No ○ Not sure / maybe

8 Do you have or have you ever had any heart or blood pressure problems?
○ Yes ○ No ○ Not sure / maybe

9 Do you have or have you ever had an artificial 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

10 Do you have a prosthetic or artificial joint?
○ Yes ○ No

11 Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy?
○ Yes ○ No ○ Not sure / maybe

12 Have you ever had hepatitis, jaundice or liver disease?
○ Yes ○ No ○ Not sure / maybe

13 Do you have a bleeding problem or bleeding disorder?
○ Yes ○ No ○ Not sure / maybe

14 Have you ever been hospitalized for any illness or operations? If yes, please explain.
○ Yes ○ No ○ Not sure / maybe

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

- ○ Chest pain, angina
- ○ Stroke
- ○ Rheumatic fever
- ○ Heart murmur
- ○ Lung disease
- ○ Cancer
- ○ Diabetes
- ○ Arthritis
- ○ Kidney disease
- ○ Drug / alcohol dependency
- ○ Heart attack
- ○ Shortness of breath
- ○ Mitral valve prolapse
- ○ Pacemaker
- ○ Tuberculosis
- ○ Steroid therapy
- ○ Stomach ulcers
- ○ Seizures (epilepsy)
- ○ Thyroid disease
- ○ 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

19 Are you nervous during dental treatment?
○ Yes ○ No ○ Not sure / maybe

20 *For women only:* Are you breastfeeding or pregnant? If pregnant what is the expected delivery date?
○ Yes ○ No ○ Not sure / maybe

Dental Information

Date of last dental check up

Have you ever seen a Periodontist? ○ Yes ○ No

Name of Periodontist

Have you ever seen an Orthodontist before? ○ Yes ○ No

If yes, when?

Have you ever had orthodontic treatment? ○ Yes ○ No

If yes, when?

Are you seen every ○ 6 months ○ 9 months ○ 12 months

Indicate any history of (check all that apply:)

- ○ Tongue thrust
- ○ Mouth breathing
- ○ Jaw joint problems
- ○ Speech/articulation problems
- ○ Heart attack
- ○ Tonsil/adenoids removed
- ○ Injury to face or teeth

What concerns do you have about your teeth?

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

Patient / Parent / Guardian signature Date

Orthodontist signature Date