MEDICAL, DENTAL & HEALTH HISTORY

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Dental personnel primarily treat the area in and around the mouth however; your mouth is a gateway to the entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for answering the following questions regarding your medical & health history.

First Name:	Last Name:	Date of Birth (D/M/Y)	Age:	Home Phone:	Cell Phone:
Email:		Home Address:		City & Province	Postal Code:
Occupation:				Employer:	
Health Card Number (OHIP)	Marital Status:	Emergency Contact: (Name)		Relationship:	Phone Number:

OFFICE USE ONLY	***CURRENT BLOOD PRESSURE READING:***

Medical History Questions

1. Do you currently have a Family Physician? Yes ☐ No ☐ Name: _____ Phone: _____

Have you visited a physician for any medical condition in the past two years? **Yes ☐ No ☐**

If yes, please explain the reason for your visit: _____

If no, when was your last visit to a Physician? _____ Date of last complete Physical Examination? _____

2. Are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Yes ☐ No ☐

3. Or have you recently taken any? Yes ☐ No ☐

If yes, please list:	Dosage: mL or mg	Frequency:
1.		
2.		
3.		
4.		
5.		
Pharmacy Name:	***Phone #:***	

4. Have you been hospitalized in the past two years? Yes ☐ No ☐

5. Have you ever reacted adversely to any of the following?

Antibiotics – Penicillin	Y ☐	N ☐	Codeine	Y ☐	N ☐
Sulfonamide	Y ☐	N ☐	Darvon	Y ☐	N ☐
Other Antibiotics	Y ☐	N ☐	Local Anesthetic (Freezing)	Y ☐	N ☐
Aspirin	Y ☐	N ☐	Nitrous Oxide	Y ☐	N ☐
Barbiturates (Sleeping Pills)	Y ☐	N ☐	Any Other Medications:		

6. Have you ever been advised against taking any specific type of medication? Yes ☐ No ☐

If yes, which medication(s): _____

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7. Do you have any of the following?

Asthma	Y ☐	N ☐	Hay Fever	Y ☐	N ☐
Food Allergies	Y ☐	N ☐	Metal or Latex Allergies	Y ☐	N ☐
Skin Rashes	Y ☐	N ☐	Hives	Y ☐	N ☐
Any Other Allergic Condition	Y ☐	N ☐	Other:		

8. Has a family member had diabetes?	Y ☐	N ☐
9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	Y ☐	N ☐
10. Do your ankles or feet swell?	Y ☐	N ☐
11. Has your weight, appetite or energy level changed dramatically lately?	Y ☐	N ☐
12. Do you experience shortness of breath or chest pain when talking a walk or climbing stairs?	Y ☐	N ☐
13. Do you follow a specific diet?	Y ☐	N ☐
14. Have you recently tested HIV positive?	Y ☐	N ☐
15. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	Y ☐	N ☐
16. Have you ever had any injury or surgery to your face or jaw?	Y ☐	N ☐
17. Do you wear eyeglasses or contact lenses?	Y ☐	N ☐
18. Do you have any hearing difficulties?	Y ☐	N ☐
19. Do you smoke or use any other forms of tobacco?	Y ☐	N ☐
a. On average, how many cigarettes do you smoke a day?	Y ☐	N ☐
b. Do you use a and kind of vape device?	Y ☐	N ☐
c. Are you wearing a transdermal nicotine patch?	Y ☐	N ☐
20. Are you alcohol and/ or drug dependant?	Y ☐	N ☐
a. Have you received any treatment?	Y ☐	N ☐

21. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD

A.I.D.S	Y ☐	N ☐	Anemia	Y ☐	N ☐	Angina Pectoris	Y ☐	N ☐
Arthritis/ Rheumatism	Y ☐	N ☐	Artificial Heart Valve	Y ☐	N ☐	Artificial Joints	Y ☐	N ☐
Blood Disorders	Y ☐	N ☐	Bronchitis	Y ☐	N ☐	Cancer	Y ☐	N ☐
Circulation Problems	Y ☐	N ☐	Congenital Heart Lesions	Y ☐	N ☐	Cortisone/ Steroid	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Emphysema	Y ☐	N ☐	Epilepsy or Seizures	Y ☐	N ☐
Fainting or Dizzy Spells	Y ☐	N ☐	Glandular Disorders	Y ☐	N ☐	Glaucoma	Y ☐	N ☐
Head/ Neck Injuries	Y ☐	N ☐	Heart Disease or Attacks	Y ☐	N ☐	Heart Murmur	Y ☐	N ☐
Heart Pacemaker	Y ☐	N ☐	Heart Rhythm Disorder	Y ☐	N ☐	Heart Surgery	Y ☐	N ☐
Hepatitis A	Y ☐	N ☐	Hepatitis B	Y ☐	N ☐	Hepatitis C	Y ☐	N ☐
Herpes	Y ☐	N ☐	High/ Low Blood Pressure	Y ☐	N ☐	Hodgkin's Disease	Y ☐	N ☐
Hyper (Hypo) Glycemia	Y ☐	N ☐	Hypertension	Y ☐	N ☐	Jaundice	Y ☐	N ☐
Kidney Disease	Y ☐	N ☐	Liver Disease	Y ☐	N ☐	Lung Disease	Y ☐	N ☐
Malignant Hyperthermia	Y ☐	N ☐	Mental/ Nervous Disorder	Y ☐	N ☐	Mitral Valve Prolapse	Y ☐	N ☐
Organ Transplant	Y ☐	N ☐	Psychiatric Treatment	Y ☐	N ☐	Radiation/ Chemotherapy	Y ☐	N ☐
Rheumatic/Scarlet Fever	Y ☐	N ☐	Sickle Cell Disease	Y ☐	N ☐	Sinus Trouble	Y ☐	N ☐
Stomach/Intestinal Problems	Y ☐	N ☐	Stroke	Y ☐	N ☐	Thyroid Disease	Y ☐	N ☐
Tuberculosis	Y ☐	N ☐	Ulcers	Y ☐	N ☐	Venereal Disease	Y ☐	N ☐
Other:								

22. Has the CHILD PATIENT recently had any of the following (indicate approximate date):

Measles	Y ☐	N ☐		Mumps	Y ☐	N ☐	
Chicken Pox	Y ☐	N ☐		Strep Throat	Y ☐	N ☐	
Tonsilitis	Y ☐	N ☐					

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23. (FOR WOMEN ONLY)

Are you pregnant or suspect you might be? Yes ☐ No ☐
If yes, what is the expected birthdate? Yes ☐ No ☐
Are you taking birth control pills? Yes ☐ No ☐

24. Do you currently have, or have you had in the past, any disease, condition, or problem not listed above?

Yes ☐ **No** ☐ _____

25. Is there anything else about your health we should be made aware of?

Yes ☐ **No** ☐ _____

26. Do you wish to speak to the Doctor privately about any problem or medical condition? Yes ☐ **No** ☐

Dental History Questions

(If you are an existing patient, please skip this section)

1. Approximate date of last dental visit? _____ **What was the reason?** _____

2. Have you ever had any of the following? Who was the treating Dentist? _____

a. Periodontal Treatment? (Treatment of the gums) **Yes** ☐ **No** ☐ _____
b. Orthodontic Treatment? (To straighten or realign teeth) **Yes** ☐ **No** ☐ _____
c. A bite plate or any other appliance or dentures? **Yes** ☐ **No** ☐ _____
d. Oral surgery? (Surgery in or about the mouth, jaw joint, or implant surgery in one or both jaw joints) **Yes** ☐ **No** ☐

If yes to "Oral Surgery," who performed the surgery? _____

3. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____

4. Have you been advised to take antibiotics before a dental appointment? _____

5. What is your *current level* of Dental Anxiety? Check the appropriate level: None ☐ Slight ☐ Moderate ☐ Severe ☐ Extreme ☐

6. Have you ever had an upsetting experience in a dental office, complications during or following dental treatment, or, do you have any questions or concerns? Yes ☐ **No** ☐

_____

What is your PRIMARY concern that you would like us to address today? _____

Would you like whiter teeth? _____

What do you like most about your smile? _____

What are you looking for to improve your oral health? _____

What do you look for most in a dental office? _____

_____

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Thank you for completing your Medical Health History for our records. Just one last Question – Please tell us how you found Grover Dental Care: *Please circle (or check) the most appropriate source:*

Google/ Internet Search ☐	Website (groverdentalcare.com) ☐	Flyer in Mail ☐	Word-of-mouth ☐
Social Media (Facebook, Instagram) ☐	Print Media (Newspaper, Magazine) ☐	Community Events ☐	Location/ Convenience of Office ☐
Specialist Office:	You are an Existing Patient (From another Grover location) Hayden ☐ Rebecca ☐ Westmount ☐ Waterdown ☐	Friend or Family Member (Their Name):	
Other (Please write in any other source):			

Patient/ Guardian Signature: _____ **Date:** _____

Reviewed by Treating Dentist: _____ **Date:** _____