North Dumfries Dentistry
www.nddentistry.ca

Medical History

Section 1: Health Information

Do you or have you had any of the following (please specify below, if applicable)?

□ AIDS/HIV	□ Cancer	□ Glaucoma	□ Kidney disease	□ Rheumatic fever
□ Anemia	□ Diabetes (Type: _____)	□ Growths or tumors	□ Liver disease	□ Rheumatism
□ Angina	□ Dizziness	□ Hay Fever	□ Lukemia	□ Sinus problems
□ Arthritis	□ Epilepsy/convulsions	□ Heart condition/disease	□ Mental health condition	□ Stomach problems
□ Artificial joints	□ Emphysema	□ Hepatitis (Type: _____)	□ Pregnancy	□ Stroke
□ Asthma	□ Excessive bleeding	□ High blood pressure	□ Radiation treatment	□ Thyroid problem
□ Blood disease	□ Fainting seizures	□ Jaundice	□ Respiratory problems	□ Ulcers

Allergies: _____

Other/specify: _____

Section 2: Dental Information

Last dental visit: _____ Last x-rays: _____

How often do you: Brush? _____ Floss? _____

Reason for today's visit: _____ Are you in pain? *Y* *N*

Do you or have you had any of the following?

□ Anaesthetic reaction	□ Cigarette smoking	□ Food trap in teeth	□ Mouth breathing	□ Strong gag reflex
□ Bad breath	□ Clicking jaw	□ Foreign objects	□ Mouth pain	□ Sensitivity to cold
□ Bad experience	□ Crowns/bridges	□ Grinding teeth	□ Orthodontic treatment	□ Sensitivity to hot
□ Bleeding gums	□ Dry mouth	□ Gums swollen	□ Pain around ear	□ Sensitivity to sweets
□ Blisters in mouth	□ Extractions	□ Jaw pain	□ Periodontal treatment	□ Sensitivity to biting
□ Burning sensation	□ Fillings	□ Lip/cheek biting	□ Removable denture	□ Sores/growths in mouth
□ Chew on one side	□ Fingernail biting	□ Loose/broken teeth	□ Root canal therapy	□ Syncope

Section 3: Medications

Please list any medications you are currently taking, or provide a list to the receptionist.

_____

_____

Section 4: Authorization

I have read and answered the questions to the best of my knowledge, and I understand that I am financially responsible for all charges whether paid by insurance or not.

_____ _____

Signature Date