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



 



Asthma



    

 



 Stroke

Jaundice

    

 

 



 Ulcers



    

 

 



Have you ever had a local anesthetic (freezing) any complications?  Yes  No  Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bridgework  Crowns or Caps  Full or Partial Dentures  Orthodontic (braces) Periodontal (Gums)  Root Canal

 H.I.V. Positive

 Hodgkin disease

 Diabetes  Hepatitis A/B/C

 Circulation problems  Heart murmur

  A.I.D.S

 Anemia

11. Women only: Are you pregnant? Yes [ ] No [ ] Using birth control? Yes [ ] No [ ] Reached menopause Yes

Milton, ON . L9T7Y9

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**\**  **/**

**FAMILY**  **DENTAL**

 Herpes

Cortisone/steroid



)

 277-113



Artificial joints hips/knees



***Date:***

***1.***

***2.***

 [ ] / [ ]

***3.***

A)

Drug.

Reason:

B)

Drug.

Reason:

 [ ] / [ ]

C)

Drug.

Reason:

 [ ] / [ ]

4. 5.

 [ ] / [ ]

6.

 [ ] / [ ]

7.

 [ ] / [ ]

8.

 [ ] / [ ]

9.

 [ ] / [ ]

[ ] / [ ]

[ ] No [ ]

 Cancer

 Epilepsy

 Glandular

 Glaucoma



 Other

 None



 Measles



 Mumps



 None



 Tonsillitis

1.



 Emergency

2.

3.

4.

 

 Floss?

 ?

5.



 Cold



 Sweet



 Other

 ?

***6.***

 Flossing

 ***Yes No***

7.

[ ] / [ ]

8.

[ ] / [ ]

9.

]

/

[

]

[

10.

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[

11.

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/

[

]

[

12.

13.

14.

]

[ ] / [

***Medical History (this information will remain confidential)***

***Are you presently under the care of a physician? If yes explain.***

 Yes / No

***Have you ever been hospitalizes? If yes explain.***

***Are you taken any drugs or medication at this time?***

Have you had any adverse effect to any of the following: ***Antibiotic-Penicillin [ ] Sulfonamide [ ] Aspirin [ ] Barbiturates ( Sleeping pills) [ ]***

***Codeine [ ] Darvon [ ] Local Anesthetic [ ] others [ ] None [ ]***

Have you been warned against using any other medical drug? Which?

Have you ever taken prolonged medical or non-medical drugs? Which?

Do you suffer from any allergies (hay lever, latex, etc. ) Which?

Dou you bruise easy or have prolonged bleeding?

Do you smoke? How many per day?

10. Have you ever fainted, had shortness of breath or chest pain?

12. Do you have or have you had any of the following please [] appropriate boxes.

 Angina pectorls

 Anorexia nervosa Artificial Heart valve

 Arthritis/heumastis

Heart diseases/attack

 congenital heart lesion  heart pacemaker/sugary

 Heart rhythm disorder

 Drug/alcohol dependence 

 kidney disease

 Liver disease

 Leukemia

 Lung disease

 Thyroid disease

 Rheumatic/Scarlet fever

sickle cell disease Sinus trouble

 Stomach/intestinal probrems

 Malignant hypothermia

 Emphysema

 high/low blood pressure

 Tuberculosis

 Mental/nervous disorder

 Blood disorders  Bronchitis

 Hyper (Hypo) Glycemia

 Mitral valve Prolapse

 Organ transplant/implant  Venereal disease

 Psychiatric disorder

 Bulimia

 Head/Neck injuries

Hypertension

 Radiation/Chemotherapy

13. CHILDEREN ONLY:

Have you recently had any of the following (Approximate date)?

 Chicken Pox

 Strep Throat

**Dental History**

What is the reason for today’s visit?

 Examination

 Other\_\_\_\_\_\_\_\_\_\_\_\_

How frequently do you see a dentist?  3-6 months

 Annually  Other

Wen was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last X-Ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush per day?

 Use anti –bacterial rinse?

Are your teeth sensitive to:

Do your gums bleed when

 Brushing 

 Never\_\_\_\_\_\_\_\_\_\_\_

Do your gums feel swollen or tender?

Do you have bad breath or bad taste in your mouth?

Do your jaws crack, pop or grate when you open widely?

Do you grind or clench your teeth?

Do you have food catch between your teeth?

Have you ever had any of the following :

Are you satisfied with your teeth? Specify

**T.** (289) 878-3900 **F.** (289)

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