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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

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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

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