Charlemagne
DENTAL CENTRE

Tel: 613-837-7500
385 Tompkins Ave.
Ottawa ON, K1E 3H4

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship: _____

Day Time Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

Mr - Mrs - Miss - Ms – Dr (please circle)

Name: _____

Date of Birth: _____ **OHIP #:** _____

Street: _____

City: _____ Prov: _____ **Email:** _____

Postal Code: _____

Home Phone: _____ **Mobile:** _____

Business: _____

We appreciate referrals. Whom may we thank for referring you or how did you learn about our office?

Patient: Name_____ Doctor: Name_____

___Web Site ____Yellow Pages ____ Location ____other: _____

Name of Family Physician: _____

MEDICAL HISTORY

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 dentist will review the questions and explain any that you do not understand. Please fill in 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. ◻ yes ◻ no ◻ not sure/maybe
_____
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 a heart murmur, mitral valve prolapse, or rheumatic fever? ◻ yes ◻ no ◻ not sure/maybe
10. Do you have a prosthetic or artificial joint? ◻ yes ◻ no ◻ not sure/maybe
11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ◻ yes ◻ no ◻ not sure/maybe
12. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ◻ yes ◻ no ◻ not sure/maybe
13. Have you ever had hepatitis, jaundice or liver disease? ◻ yes ◻ no ◻ not sure/maybe
14. Do you have a bleeding problem or bleeding disorder? ◻ yes ◻ no ◻ not sure/maybe
15. Have you ever been hospitalized for any illness or operation? If yes please explain. ◻ yes ◻ no ◻ not sure/maybe
16 Do you have or have you ever had any of the following? Please check.

◻ chest pain, angina ◻ shortness of breath ◻ pacemaker ◻ steroid therapy ◻ seizures (epilepsy) ◻ arthritis
◻ drug/alcohol dependency ◻ heart attack ◻ stroke ◻ prosthetic heart valve
◻ lung disease ◻ tuberculosis ◻ cancer ◻ diabetes ◻ stomach ulcers ◻ thyroid disease
◻ diet pill therapy ◻ kidney disease

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ◻ yes ◻ no ◻ not sure/maybe
18. Are there any diseases or medical problems that run in your family? ◻ yes ◻ no ◻ not sure/maybe
19. Do you smoke or chew tobacco products? ◻ yes ◻ no
20. Are you nervous during dental treatment? ◻ yes ◻ no ◻ not sure/maybe
21. Women only: are you breast-feeding or pregnant? If pregnant what is the expected delivery date? ◻ yes ◻ no ◻ not sure/maybe