Vista Dental (www.Vistadental.ca)

Medical History Questionnaire In Case of an Emergency who should we notify

\*First Name Name

\*Last Name Relationship

Middle Name Phone

\*Date of Birth (DD/MM/YY) Name of Medical Doctor

\*Address **Phone**

**\* City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Postal Code \_\_\_\_\_\_\_\_ *Do you have dental ins? Yes O no O***

***Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_* appointments are confirmed by email or text**

\*Email *name of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\*Phone (Home) *date of birth of insured*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (cell) ***policy #*\_\_\_\_\_\_\_\_\_\_\_ *certificate #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

How Were you Referred to our Office?

🞎 Referred by MD (Name) 🞎 Referred by Friend/Colleague (Name)

🞎 Our Website 🞎 Internet Search (ie. Google, Bing, etc.)

🞎 Other

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?**

🞎 Yes 🞎 No 🞎Not Sure Maybe

If yes, Why?

1. **When was your last check up?**
2. **Has there been any change in your general health in the past year?** 🞎 Yes 🞎 No 🞎Not Sure

If yes, Explain why?

1. **Are you taking any medications, non-prescription drugs or herbal supplements?** 🞎 Yes 🞎 No 🞎Not Sure

If yes, Explain why?

1. **Have you ever had a peculiar or adverse reaction to any medicines or injections?** 🞎 Yes 🞎 No 🞎Not Sure

If yes, Explain why?

1. **Do you have any allergies? If you answered yes, please list using the categories below:**

🞎 Yes 🞎 No 🞎Not Sure Maybe

1. Medications
2. Latex/rubber products
3. Other (e.g. hay fever, foods)
4. **Do you have or have you ever had asthma?**  🞎 Yes 🞎 No 🞎Not Sure
5. **Do** **you have or have you ever had any heart or blood pressure problems?** 🞎 Yes 🞎 No 🞎Not Sure
6. **Do you have or ever had a replacement or repair of a heart valve, an infection of the heart (ie infective edocarditis) a heart condition from birth (ie congenital heart disease) or a heart transplant?** 🞎 Yes 🞎 No 🞎Not Sure
7. **Do you have a prosthetic or artificial leg?** 🞎 Yes 🞎 No 🞎Not Sure
8. **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
9. **Have you ever had hepatitis, jaundice or liver disease?** 🞎 Yes 🞎 No 🞎Not Sure
10. **Do you have a bleeding problem or bleeding disorder?** 🞎 Yes 🞎 No 🞎Not Sure
11. **Have you ever been hospitalized for any illnesses or operations?** 🞎 Yes 🞎 No 🞎Not Sure

If yes, Explain why?

1. Do you have or have you any of the following? Please check.

🞎 Chest pain, angina 🞎Rheumatic fever 🞎pace maker 🞎 Steroid therapy 🞎 Seizures 🞎 Osteoporosis Medication

🞎 Heart Attack🞎 Mitral valve Prolapse 🞎 Lung disease 🞎 Diabetes 🞎 Kidney Disease 🞎Stroke 🞎 Tuberculosis 🞎 Stomach ulcers 🞎 Thyroid Disease 🞎 Drug/alcohol dependency 🞎 Arthritis 🞎 Cancer 🞎 Heart murmur 🞎 Shortness of breath

1. **Are there any conditions or diseases not listed above that you have or ever had?** 🞎 Yes 🞎 No 🞎Not Sure

If yes, Explain what?

1. **Are there any diseases or medical problems that run in your family? (e.g Diabetes)**  🞎 Yes 🞎 No 🞎Not Sure
2. **Do you smoke Tobacco products?** 🞎 Yes 🞎 No 🞎Not Sure
3. \*\*\*For Women Only\*\*\* Are you breastfeeding or pregnant? 🞎 Yes 🞎 No

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date: