NEW PATIENT MEDICAL HISTORY FORM

Please complete all three pages

- Name (first, last) _____
- Address (street no. & name, city, postal code) _____
- Phone number _____
- Email address _____
- Date of birth (MM-DD-YY) _____
- Do you currently have dental insurance? ❑ Yes ❑ No
  If yes, please state: employer name _____
  policy no. _____
  ID certificate no. _____
  insurance company name _____
- Physician's: name (first, last) _____
  address (street no. & name, city, postal code) _____
  phone number _____
- Emergency contact: name (first, last) _____
  phone number _____
- How did you find out about us? _____

Health History

- Reason for seeking dental hygiene care at this time? _____
- Are you in good general health? ❑ Yes ❑ No
- Any change in your general health in the past year? ❑ Yes ❑ No
- Are you under the care of a physician? ❑ Yes ❑ No
- Have you been hospitalized or had a serious illness or operation? ❑ Yes ❑ No
- Have you ever had any complications following dental treatment? ❑ Yes ❑ No
- Would you say your diet is adequate and balanced? ❑ Yes ❑ No
- Do you smoke? ❑ Yes ❑ No If yes, would you like to quit smoking? ❑ Yes ❑ No

Medications / Allergies

- Are you taking any medications – prescribed or over-the-counter? ❑ Yes ❑ No
  If yes, please specify _____
- Are you allergic to any medications, foods, drugs, metals, latex? ❑ Yes ❑ No
  If yes, please specify _____
- Have you ever had hives? ❑ Yes ❑ No
- Have you experienced an unusual reaction or allergy to penicillin, aspirin, sulpha drugs, codeine, cortisone (steroids), local anaesthetics, topical anaesthetics, or other medications, food, dental latex? ❑ Yes ❑ No If yes, please specify_____
- Do you have a drug/alcohol dependency? ❑ Yes ❑ No
- Do you use marijuana for leisure or as medication? ❑ Yes ❑ No

Cardiovascular System

If yes, please circle which one(s):

- Heart disease, heart failure, heart attack, chest pain ❑ Yes ❑ No
- Angina pectoris, pacemaker, artificial heart valves ❑ Yes ❑ No
- History of infective endocarditis ❑ Yes ❑ No
- Congenital heart disease, swollen ankles ❑ Yes ❑ No
- Shortness of breath, heart surgery/bypass ❑ Yes ❑ No
- High blood pressure, low blood pressure ❑ Yes ❑ No

Blood Conditions

If yes, please circle which one(s):

- Cerebrovascular accident (stroke), anaemia ❑ Yes ❑ No
- Prolonged bleeding or blood disorder, leukaemia ❑ Yes ❑ No
- Haemophilia, bruise easily, heal slowly ❑ Yes ❑ No
- Immunodeficiency problems, HIV, AIDS, lupus, sickle cell anaemia ❑ Yes ❑ No
- Have you ever had a blood transfusion? ❑ Yes ❑ No

Respiratory System

If yes, please circle which one(s):

- Lung disease, persistent cough or cold ❑ Yes ❑ No.
- Tuberculosis, emphysema ❑ Yes ❑ No
- Bronchitis, pneumonia, asthma/hay fever ❑ Yes ❑ No
- Shortness of breath, sinus problem ❑ Yes ❑ No
- Stomach ulcers/acid reflux, hepatitis (A, B or C, other) ❑ Yes ❑ No
- Diabetes controlled/uncontrolled, if yes, Type I (insulin dependent) or Type II ❑ Yes ❑ No
- Have you ever had any treatment for a tumour or growth? ❑ Yes ❑ No
- Have you ever had radiation or chemotherapy for cancer or leukaemia? ❑ Yes ❑ No
- Have you ever had an organ transplant? ❑ Yes ❑ No
- Have you had any other condition or disease not previously mentioned? ❑ Yes ❑ No

Dental History

- Date of last dental/dental hygiene visit _____
- What dental conditions concern you at the present time? _____
- What care did you receive at your last dental visit? _____
- How often do you receive dental treatment or dental hygiene care? _____
- Do you require complete mouth care or emergency treatment? ❑ Yes ❑ No
- Are you under the care of a dental specialist? (i.e., orthodontist, endodontist, prosthodontist, periodontist) ❑ Yes ❑ No
- Have you ever had a thorough examination of your mouth including a complete set of radiographs of your jaws and teeth? ❑ Yes ❑ No If yes, when? _____
- Have you had radiographs (dental x-rays) in the past two years? ❑ Yes ❑ No
- Have you had any dental problems within the last year with your teeth, gums, jaws, chewing? ❑ Yes ❑ No If yes, please specify _____

In order that we may be sensitive to your needs, please tell us of any unpleasant experiences you may have had related to oral care _____

Do you have or have you ever experienced any of the following?

If yes, please circle which one(s):

- Sensitive teeth (hot or cold), cold sores ❑ Yes ❑ No
- Bleeding gums (on brushing), sore gums ❑ Yes ❑ No
- Loose teeth, dry mouth ❑ Yes ❑ No
- Recession, bad breath ❑ Yes ❑ No
- Swelling, sinus problems ❑ Yes ❑ No
- Sore jaw, jaw clicks or pops on opening or closing ❑ Yes ❑ No
- Mouth sores, difficulty chewing ❑ Yes ❑ No
- Difficulty swallowing, burning sensation ❑ Yes ❑ No
- Fractured or broken filling, abscess ❑ Yes ❑ No
- Yellowing or discolouration of teeth ❑ Yes ❑ No
- Grinding and/or clenching of teeth – any accident, injury or surgery to your face, jaw or teeth? ❑ Yes ❑ No

Current Oral Condition

- How often do you brush your teeth? _____
- How often do you floss your teeth? _____
- What oral aids do you routinely use at home? _____
- Do you have complete dentures, partial dentures, fixed bridges, or implants? ❑ Yes ❑ No
- Are you a mouth breather? ❑ Yes ❑ No
- Are you pregnant? ❑ Yes ❑ No
- Are you nursing? ❑ Yes ❑ No
- Are you taking birth control medications? ❑ Yes ❑ No

Once completed, please print out and bring with you to your appointment along with your dental insurance card. Thank you.

All information disclosed on this form will remain strictly confidential.

I hereby consent to receiving dental hygiene care from L&L Dental Hygiene Clinic and email regarding all dental treatment.

Patient signature _____ Date (MM-DD-YY) _____

Parent/guardian signature (if applicable) _____

Hygienist signature _____ Date (MM-DD-YY) _____