DENTISTRY ON AIRPORT

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Medical History / Dental Questionnaire

MEDICAL ALERT

MR / MISS / MRS. / MS / DR.

NAME:

Occupation:

Date of Birth: MM / DD / YYYY

ADDRESS (HOME):

EMAIL:

PHONE:

ALTERNATIVE PHONE:

HEALTH CARD:

PHARMACY:

DO YOU CONSENT TO EMAIL / TEXT MESSAGE APPOINTMENT REMINDERS?

☐ Yes ☐ No

HOW DID YOU HEAR ABOUT US?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

PHONE:

NAME OF FAMILY DOCTOR:

PHONE:

NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE:

PREVIOUS DENTIST:

EMAIL:

PHONE:

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 anything that you do not understand. Please fill in the entire form.

1. Are you currently being treated for any medical condition or have you been treated within the past year?
   If yes, please explain. ☐ 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 them. ☐ Yes ☐ No ☐ Not Sure / Maybe

5. Do you have any allergies? ☐ Yes ☐ No ☐ Not Sure / Maybe
If yes, please list them using the categories below
a) medications / anesthetic _____
b) latex / rubber products / metal _____
c) other (e.g. hay fever, seasonal / environmental, foods) _____

6. Have you ever had a peculiar or adverse reaction to any medicines / injections or topical anesthetic gel? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure / Maybe

_____

7. Have you had any organ transplant / removal? ☐ Yes ☐ No ☐ Not Sure / Maybe

_____

8 . Do you have or have you ever had any of the following? Please check.

- ☐ Chest pain, angina
- ☐ Heart attack
- ☐ Stroke, TIA
- ☐ Heart murmur
- ☐ Blood thinners
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Cholesterol
- ☐ Malignant hyperthermia
- ☐ Low blood pressure
- ☐ Stent placement
- ☐ Tuberculosis
- ☐ Lung disease/COPD
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Seizures (epilepsy)
- ☐ Stomach ulcers
- ☐ Myasthenia gravis
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Kidney disease
- ☐ Rheumatic fever
- ☐ Arthritis / rheumatoid arthritis / Osteoarthritis
- ☐ Osteoporosis medications (e.g. Fosamax, Actonel)
- ☐ Prolia injections
- ☐ Bleeding disorder hemophilia
- ☐ Cancer
- ☐ Chemotherapy/ radiation
- ☐ Steroid therapy
- ☐ Drug / alcohol / cannabis use or dependency
- ☐ Anxiety/ depression
- ☐ Dementia

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? If yes, please provide details

☐ Yes ☐ No ☐ Not Sure / Maybe

_____

10. Do you have a prosthetic or artificial joint? If yes, when?

☐ Yes ☐ No ☐ Not Sure / Maybe

If yes, when was the surgery?

_____

11. Do you require a premed? ☐ 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? If yes, when?

☐ Yes ☐ No ☐ Not Sure / Maybe

_____

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain

☐ Yes ☐ No ☐ Not Sure / Maybe

_____

15. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure / Maybe

16. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?
☐ Yes ☐ No ☐ Not Sure / Maybe

17. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure / Maybe

18. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure / Maybe

19. Do you have a disability? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure / Maybe

20. Do you have or have you ever had sleep apnea? If yes, have you been treated? Please explain
☐ Yes ☐ No ☐ Not Sure / Maybe

21. Are you using any recreational drugs? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure / Maybe

22. Have you ever had Oral Sedation, IV Sedation or General Anesthesia before?
☐ Yes ☐ No ☐ Not Sure / Maybe

23. Did you have any complications during or after that? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure / Maybe

FOR WOMEN ONLY

1. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not Sure / Maybe

2. Are you taking birth control pills? ☐ Yes ☐ No

Dental Questionnaire

1. What is your chief dental concern?

2. Do you have any discomfort or pain in your mouth? If yes, where? ☐ Yes ☐ No

3. How many times a day do you brush your teeth? ☐ None ☐ 1 ☐ 2 ☐ 3+

4. How many times a day do you floss? ☐ None ☐ 1 ☐ 2+

5. Do you wear dentures? ☐ Yes ☐ No

6. Are you happy with your smile? If no, what would you like to change? ☐ Yes ☐ No

7. Do you have any piercings? ☐ Yes ☐ No

If yes, where? ☐ Tongue ☐ Lip ☐ Brow ☐ Ear ☐ Other: _____

CONSENT: The undersigned hereby authorizes the Doctor to take x-rays, study models, photos, or any other diagnosis of my (or the patients) dental needs. I also authorize the Doctor to perform all forms of treatment, medication and therapy that may be required. I also understand that the use of anesthetic agents embodies a certain risk. Where possible, I will be asked for verbal consent or permission before any and all treatment is done and x-rays taken.

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

Patient / Parent / Guardian Signature: _____ Date: _____

Dentist / Hygienist Signature: _____ Date: _____

FOR OFFICE USE ONLY

ASA Classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Max Mouth Opening: _____

Mallampati Classification: ☐ I ☐ II ☐ III ☐ IV

DENTIST / HYGIENIST NOTES: