AJL DENTISTRY

HEALTH HISTORY QUESTIONNAIRE

Your health history is very important to us. In order to help us provide personalized dental care, please answer all questions on this form as thoroughly and as accurately as possible. The information collected herein will be kept strictly confidential.

MEDICAL HISTORY (Please PRINT Clearly)

Name: ____

Date of Birth__________________ **EMAIL:**________________________________

Phone Number: ________________ **Cell Number:**_________________________

Mailing Address: ____

Family Physician:_____________________Physician's Phone Number:___________________________

Last Medical Check-up:________________________

Have you ever been hospitalized or had a serious illness? **YES** **NO**

If Yes, please explain:____

Are you being treated for any medical condition now or within the past year? **YES** **NO**

If Yes, Please explain:____

Are you currently taking any medications, non-prescription, or herbal products? **YES** **NO**

If Yes, please list: ____

____

____

Have you ever had an allergic reaction? Please circle any applicable:

Medication Anesthetic Latex/Rubber Products Food

Please List Allergies:____

____

What is severity of allergic reaction?____

Have you ever had an adverse reaction to injections? **YES** **NO**

Any Contraindications to medications? **YES** **NO**

Required per-medication prior to treatment? **YES** **NO**

If yes, please list:____

(Women only) **Are you pregnant/ or breastfeeding? ______ If yes, how many months?_____**

Are you on Birth Control pills?

For the following, please indicate YES or NO if you have had, or currently have.

Cardiovascular

Angina	Yes	No	Stroke	Yes	No
Chest pain	Yes	No	Heart disease/attack	Yes	No
Endocarditis	Yes	No	Prosthetic Heart Valve	Yes	No
Heart Transplant	Yes	No	Congenital heart lesions/defects	Yes	No
Heart pacemaker	Yes	No	Heart Murmur	Yes	No
Heart rhythm disorder	Yes	No	Heart surgery	Yes	No
Hypertension	Yes	No	Ankle feet, hands swell	Yes	No
Circulation problems	Yes	No	Heart or blood pressure problems	Yes	No
Mitral valve prolapse	Yes	No	Rheumatic fever	Yes	No

Respiratory

Asthma	Yes	No	Bronchitis	Yes	No
Shortness of breath	Yes	No	Emphysema	Yes	No
Lung disease	Yes	No	Tuberculosis	Yes	No

Endocrine

Diabetes	Yes	No	Hypoglycemia	Yes	No
Glandular disorders	Yes	No	Thyroid disease	Yes	No

Skeletal

Arthritis	Yes	No	Past injury/surgery to jaw/face	Yes	No
Head/Neck injury	Yes	No	Artificial joints (hip/knee)	Yes	No

Blood/Immune

HIV/AIDS	Yes	No	Anemia	Yes	No
Blood disorders	Yes	No	Sickle cell disease	Yes	No
Bleeding disorder	Yes	No			

GI

Crohn’s disease	Yes	No	Inflammatory bowel disease	Yes	No
Ulcers	Yes	No			

Other

Liver disease	Yes	No	Jaundice	Yes	No
Hepatitis A, B, C	Yes	No	Kidney disease	Yes	No
Cancer	Yes	No	Chemo/Radiation	Yes	No
Hodgkin's disease	Yes	No	Glaucoma	Yes	No
Herpes/Cold sores	Yes	No	Malignant Hyperthermia	Yes	No
Lupus	Yes	No	Medical implant	Yes	No
Organ transplant	Yes	No	Hearing difficulty	Yes	No
Sinus Problems	Yes	No	Cortisone/Steroid	Yes	No
Seizures/Epilepsy	Yes	No	Fainting/Dizzy spells	Yes	No
Mental/nervous disorder	Yes	No	Venereal disease	Yes	No

Are there any diseases or medical problems that run in your family?________________________________

Is there anything else we should know?____

____

____

SOCIAL HISTORY

How many alcoholic beverages do you consume in a week? ______________________________________

Do you use tobacco/tobacco products? YES NO If yes, how much?___________

Do you use any recreational drugs? YES NO If yes, how often?___________

DENTAL HISTORY

When was your last dental visit? ____

1. Does Dental treatment make you nervous? NO Slightly Moderately Extremely
2. Are you apprehensive about dental treatment? YES NO
3. Do you gag easily? YES NO
4. Does food catch between your teeth? YES NO
5. Are your teeth sensitive? YES NO
6. Do you feel that you have sensitive teeth when in contact with:
    a. *Hot foods or liquids?* *YES* *NO*
    b. *Cold foods or liquids?* *YES* *NO*
    c. *Sours?* *YES* *NO*
    d. *Sweets?* *YES* *NO*
7. Do you clench or grind your jaws frequently? YES NO
8. Do your jaws ever feel tired? YES NO
9. When did you last have dental x-rays taken? ____
10. How often do you brush your teeth?____
11. How often do you use dental floss? ____
12. Do you take fluoride supplements? YES NO
13. Have you ever had local anaesthetic (freezing)? YES NO
    If yes, any complications?
    ____
14. What are your primary dental concerns?____
15. Are you satisfied with the appearance of your teeth? YES NO

I understand the above collected information is necessary to provide me with personalized dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be required in order to provide dental care, you have my permission to ask the respective health care provider who may release such information to you. I will notify the dental team of any changes in my health or medication.

NAME:____**SIGNATURE:**______________________________

DATE:__________________________