Dentistry on Bayview
Family Dentistry

Medical History Form

Name: _____

Preferred Name/Nickname: _____ Date of Birth: _____

Address: _____ City: _____ PC: _____

Email: _____

Main Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Contacts Number: _____

Preferred Method(s) of contact: ☐ Phone ☐ Text ☐ Email

Medical Physician: _____

Physicians Number: _____ Last Seen?: _____

Medical Specialist: _____

Specialists Number: _____ Last Seen?: _____

Referred by: _____ Please Specify: _____

Do you have Dental Insurance Benefits? ○ Yes ○ No If yes, please provide your benefits card to us.

Dental History *

1. Have you ever had a negative dental experience? _____
2. Have you ever had complications following dental treatment? _____
3. Do you have trouble getting numb with local anesthetics? _____
4. Do you have sore or bleeding gums? _____
5. Do you experience tooth sensitivity? _____
6. Have you had teeth removed before? _____
7. When was your last visit to a dental office? _____ Reason? _____
8. When were your last xrays taken? _____
9. What is the reason for your visit today? _____

Health History *

Heart Attack	○ Yes	○ No	Fainting	○ Yes	○ No
Heart Disease	○ Yes	○ No	Dizzy Spells	○ Yes	○ No
Heart Murmur	○ Yes	○ No	Epilepsy/Seizures	○ Yes	○ No
Angina (Chest Pain)	○ Yes	○ No	Dementia	○ Yes	○ No
Stroke	○ Yes	○ No	Sensory Disorder	○ Yes	○ No
Arrhyhmia	○ Yes	○ No	Psychiatric Treatment	○ Yes	○ No
Congenital Heart Defect	○ Yes	○ No	Learning/Behavior Disorder	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No	Eating Disorder	○ Yes	○ No
Artificial Valve	○ Yes	○ No	MRSA	○ Yes	○ No
Rheumatic Fever	○ Yes	○ No			
Pacemaker	○ Yes	○ No	Jaundice	○ Yes	○ No
Heart Surgery	○ Yes	○ No	Bladder Problems	○ Yes	○ No
Aneurysm	○ Yes	○ No	Kidney Problems	○ Yes	○ No
High Cholesterol	○ Yes	○ No	Kidney Transplant	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Urinary Tract Infection	○ Yes	○ No
Glaucoma	○ Yes	○ No	Prostate Issues	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Skin Cancer	○ Yes	○ No
Easy Bruising	○ Yes	○ No	Skin Rashes	○ Yes	○ No
Bleeding Tendency	○ Yes	○ No	Skin Ulcers	○ Yes	○ No
Anaemia	○ Yes	○ No	Arthritis	○ Yes	○ No
Sickle Cell Disease	○ Yes	○ No	Gout	○ Yes	○ No
Haemophilia	○ Yes	○ No	Artificial Joints	○ Yes	○ No
Leukemia	○ Yes	○ No	Sore Muscles	○ Yes	○ No
Methemoglobinemia	○ Yes	○ No	Night Sweats	○ Yes	○ No
			Osteoporosis	○ Yes	○ No
Pregnant	○ Yes	○ No			
Breastfeeding	○ Yes	○ No	Diabetes	○ Yes	○ No
Birth Control Use	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
			Hodgkin's Disease	○ Yes	○ No
Malignant Hyperthermia	○ Yes	○ No	Grave's Disease	○ Yes	○ No
Crohn's Disease	○ Yes	○ No	HIV/AIDS	○ Yes	○ No
Ulcerative Colitis	○ Yes	○ No	Hepatitis Infection A/B/C	○ Yes	○ No
Celiac Disease	○ Yes	○ No	Liver Disease	○ Yes	○ No
Ulcers	○ Yes	○ No	Cirrhosis	○ Yes	○ No
GERD/Acid Reflux	○ Yes	○ No	Cold Sores	○ Yes	○ No
Difficulty Swallowing	○ Yes	○ No	Sleep Disorders	○ Yes	○ No
			Tobacco Use	○ Yes	○ No
Hay Fever	○ Yes	○ No	Cannabis Use	○ Yes	○ No
Sinus Problems	○ Yes	○ No	Organ Transplant	○ Yes	○ No
Tuberculosis	○ Yes	○ No	Hearing Impairment	○ Yes	○ No
Asthma	○ Yes	○ No	Fibromyalgia	○ Yes	○ No
Emphysema	○ Yes	○ No			
Chronic Cough	○ Yes	○ No	Alcohol Use	○ Yes	○ No
Shortness of Breath	○ Yes	○ No	Cancer or Tumor	○ Yes	○ No
Cycstic Fibrosis	○ Yes	○ No	Lupus	○ Yes	○ No

COPD	○ Yes	○ No	Substance Abuse	○ Yes	○ No
			Radiation/Chemotherapy	○ Yes	○ No
Severe Headaches	○ Yes	○ No	Immune Compromised	○ Yes	○ No
Migraine Headaches	○ Yes	○ No			

List any other conditions not mentioned above:

Please explain any 'Yes' answers:

Please list any medications including prescriptions, over-the-counter, and natural health products:

Have you experienced an allergic reaction to any of the following: *

Metals	○ Yes	○ No	Ibuprofen (Advil)	○ Yes	○ No
Aspirin	○ Yes	○ No	Codeine	○ Yes	○ No
Penicillin	○ Yes	○ No	Latex	○ Yes	○ No
Local Anaesthetics	○ Yes	○ No	Sulphites	○ Yes	○ No
Tylenol	○ Yes	○ No	Sulpha	○ Yes	○ No

Other: _____

Patient Consent *

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable. I understand that the use of local anaesthetics is commonly required for dental procedures and that there are some possible risks associated with any injection including but not limited to: traumatic injuries and soreness from the injection, rapid heartbeat, temporary or permanent injury to nerves.

I am responsible for the fees associated with my treatment, and I agree to pay for any amounts not covered by my dental benefits plan.

Signature: _____ Date: _____