KEELE&SHEPPARD DENTISTRY

Medical/Dental History Update

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

_____ _____, (_____) D.O.B. _____Gender: M F

First Name Last Name Preferred Name dd/mm/yy

Patient Street Address: _____

City: _____ Postal Code: _____ Email: _____

Home Phone: ( ) _____ Cell: ( ) _____ Other: ( ) _____

Physician: _____Phone: ( ) _____ Pharmacist: ( ) _____

Emergency Contact: _____ Relation: _____ Phone: ( )_____

Ins Company Name: _____ *Employer Name:* _____

Subscriber: _____*D.O.B*_____ Dental Policy/Group #_____

ID/Certificate#_____ who may we thank for referring you to us? _____

Dental History

Have you ever had a negative dental experience? ..... ☐ Yes ☐ No
Please explain. _____
Are you generally tense during dental visits? ..... ☐ Yes ☐ No

Periodontal History

Are you aware of bad breath or a bad taste in your mouth? ..... ☐ Yes ☐ No
Does food routinely get wedged between your teeth? ..... ☐ Yes ☐ No
Does your mouth tend to be dry? ..... ☐ Yes ☐ No
Are your parents or siblings missing any of their natural teeth? ..... ☐ Yes ☐ No

Habits

Do you smoke cigars or cigarettes? Recreational smoking? (circle all that apply) If so, how many? _____
Do you chew on pencils, gum, ice cubes, or popcorn kernels? Etc.(circle all that apply) ..... ☐ Yes ☐ No
Do you bite your fingernails, pins, or use a pipe? Etc. (circle all that apply) ..... ☐ Yes ☐ No
Do you drink coffee, tea, or cola drinks? (circle all that apply) How often? _____ ☐ Yes ☐ No
Do you bite your lips or cheeks regularly? ..... ☐ Yes ☐ No
Do you breathe through your mouth when awake or asleep? ..... ☐ Yes ☐ No
Do you snore during sleep? ..... ☐ Yes ☐ No
Do you participate in any sports? If so, what kind? _____ ☐ Yes ☐ No

Aesthetics

Are you satisfied with the appearance of your teeth and smile? ..... ☐ Yes ☐ No
Would you be interested in knowing more about veneers, bonding, tooth whitening, implants,
other cosmetic options? (circle all that apply) ..... ☐ Yes ☐ No
If you could wave a magic wand, what would you change about your smile?

_____

Continued on Back >>>

Medical History

Are you in good health? ..... ☐ Yes ☐ No
When was your last complete medical examination? ..... Date: _____
Have you ever been hospitalized for a serious illness or operation? ..... ☐ Yes ☐ No
Please explain. _____
Are you currently taking any prescription or non-prescription medications? ..... ☐ Yes ☐ No
If yes, please list. _____
Do you have any allergies? Including: Medications, foods, latex, environmental, other? ..... ☐ Yes ☐ No
If yes, please list. _____
Have you ever had a previous reaction to metal or metal jewellery? ..... ☐ Yes ☐ No
Have you ever had an adverse reaction to dental freezing, general anaesthetic, penicillin, codeine, aspirin, or other drugs? (circle those that apply) ..... ☐ Yes ☐ No
If yes, what kind of reaction? _____
Do you suffer from canker sores or cold sores? ..... ☐ Yes ☐ No
Are you subject to prolonged bleeding, and/or do you bruise easily? ..... ☐ Yes ☐ No
Have you ever fainted? What were the circumstances? _____ ☐ Yes ☐ No
Have you ever experienced any recent unexplained weight change, or increased thirst, appetite, or frequency of urination? ..... ☐ Yes ☐ No
Have you ever had a shortness of breath or pains in your chest? ..... ☐ Yes ☐ No
Have you had or ever been treated for rheumatic fever, rheumatic, or congenital heart disease? ..... ☐ Yes ☐ No
Do you have a heart condition of any kind? (angina pectoris, arrhythmias, or previous heart attack – please circle) .... ☐ Yes ☐ No
Has your physician ever told you that you have a heart murmur or mitral valve prolapse? ..... ☐ Yes ☐ No
Have you had any organ transplants or joint replacements? If yes, when? _____ ☐ Yes ☐ No
Do you have a prosthetic heart valve or wear a pacemaker? ..... ☐ Yes ☐ No
Have you been told by your medical doctor that you need to take antibiotics before dental treatment? ..... ☐ Yes ☐ No
Have you ever been treated for Hepatitis? Which type? _____ ☐ Yes ☐ No
Do you have or have you had any of the following diseases or conditions? (please circle all that apply) ..... ☐ Yes ☐ No

Anaemia or blood disorders	Kidney or Liver disease	Diabetes, Hyper or Hypoglycemia	Alzheimer's or Parkinson's
High or low blood pressure	Venereal disease	Thyroid Disease	Multiple Sclerosis
Stroke	Mental or nervous disorders	Ulcers or other stomach disorders	Arthritis or Rheumatism
Tuberculosis or Asthma	Epilepsy or Seizures	Gall bladder disorders	Osteoporosis
Emphysema or other lung disease	Down syndrome or Cerebral Palsy	Attention Deficit Disorder	AIDS or HIV+
Deafness or Blindness	Sinus or Nasal problems	Eczema or Psoriasis	Cancer

Other: _____
Are you on any special diet? (e.g. salt restricted diet) _____ ☐ Yes ☐ No
Do you wear contact lenses? ..... ☐ Yes ☐ No
WOMEN ONLY: Are you pregnant? If yes, how many months? _____ ☐ Yes ☐ No
Are you taking birth control pills? ..... ☐ Yes ☐ No
Are you menopausal or post-menopausal? If yes, are you on hormone replacement therapy? ..... ☐ Yes ☐ No

On a scale of 1 to 5, please rate your current dental health. Excellent 1 2 3 4 5 Very Poor
What priority do you place on your dental health? Highest Priority 1 2 3 4 5 Lowest Priority

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I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. Should the need arise, I allow my medical doctor to be consulted. I understand that I am financially responsible to the dentist for all necessary treatment.

Signature: _____ Date: _____
Dentist: _____ Date: _____