DentalHygieneCare

Cindy Hernandez, RDH

Medical Alert☐

All information will remain strictly confidential **Date:**

PERSONAL

First Name: Initial: Last Name:

Address: Apt#: City: Prov.: Postal Code:

Birthdate: M / D / Y Home tel: Cell: Work:

E-mail Address: How did you hear about us?

Emergency Contact Person: Tel:

MEDICAL HISTORY

Family Doctor: Address: Tel:

When was your last medical checkup or visit? Do you have any allergies? no☐ yes☐

Are you being treated for any medical condition at the present or have you been treated within the past year? no☐ yes☐ If so, why?

Has there been any change in your general health in the past year? no☐ yes☐ describe:

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? no☐ yes☐

List:

Do you have or have you ever had any of the following? Please check the appropriate boxes:

- ☐ Anemia/sickle cell disease
- ☐ Angina pectoris
- ☐ Anorexia nervosa
- ☐ Artificial heart valve
- ☐ Arthritis/rheumatism
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital heart lesions
- ☐ Cortisone/steroid problems
- ☐ Diabetes, hyper/hypo glycemia
- ☐ Drug/alcohol dependence
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/neck injuries
- ☐ Heart disease/attack
- ☐ Heart murmur
- ☐ Heart pacemaker/surgery
- ☐ Heart rhythm disorder
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ High/low blood pressure
- ☐ H.I.V. Positive / A.I.D.S
- ☐ Hodgkin's disease
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Leukemia
- ☐ Lung disease
- ☐ Malignant hypothermia
- ☐ Mental/nervous disorder
- ☐ Mitral valve prolapse
- ☐ Organ transplant/implant
- ☐ Psychiatric disorder
- ☐ Radiation/chemotherapy
- ☐ Rheumatic/scarlet fever
- ☐ Sinus trouble
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other:
- ☐ **None**
- ☐ **antibiotic required for dental treatment**

Are you pregnant?

DENTAL HISTORY

Dentist: Address: Tel:

How long ago was your last dental/dental hygiene visit?

Are you under the care of a dental specialist (e.g. ortho, endo, periodontist) no☐ yes☐

Have you ever had any complications or bad experiences following dental treatment? no☐ yes☐ describe:

Have you ever had the following: periodontal/gum disease☐ implants☐ bridgework☐ crowns/caps☐ root canal therapy☐ braces☐ dentures☐ local anaesthetic (freezing) for dental cleanings☐

Do you presently have any of the following conditions:

- ☐ abcess
- ☐ accident, injury or surgery to your face, jaw or teeth
- ☐ bleeding gums: brushing☐ flossing☐
- ☐ food catch between teeth
- ☐ sensitive teeth: cold☐ sweets☐ heat☐ other☐
- ☐ yellowing or discoloration of teeth
- ☐ bad breath
- ☐ broken filling
- ☐ burning sensation
- ☐ cold sores
- ☐ difficulty breathing through the nose
- ☐ difficulty chewing
- ☐ difficulty swallowing
- ☐ dry mouth
- ☐ grinding of teeth
- ☐ loose teeth
- ☐ mouth sores
- ☐ recession
- ☐ swelling
- ☐ sore gums
- ☐ sore jaw
- ☐ tartar build-up
- ☐ toothache
- ☐ any concerns:

Rate your smile from 1 to 10 (1 = very unsatisfied, 10 = very satisfied): 1 2 3 4 5 6 7 8 9 10

What would you like to change?

Do you smoke? no☐ yes☐ How many years: per day: would you like more information about quitting? no☐ yes☐

Do you consume alcohol regularly? no☐ yes☐ How many drinks per day/week:

Financial information Method of payment: insurance☐ ODSP☐ cash☐ mastercard☐ visa☐ debit☐