Alexander
Dental Centre

Alexander Dental Centre

Health History Form

As required by Royal College of Dental Surgeons of Ontario, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential.
This information is important to allow us to provide appropriate care for you.

Name:

Home Phone:

Cell Phone:

Work Phone:

Email:

Address:

City:

Province:

Postal Code:

Emergency Contact:

Relationship:

Cell Phone:

Date of Birth:

Height:

Weight:

Gender: ◯ Male ◯ Female

If you are completing this form for another person, what is your relationship to that person?

Your Name:

Relationship:

Do you have any of the following diseases or problem *(check Unknown if you don't know the answer to the question)*:

• Active tuberculosis	◯ Yes	◯ No	◯ Unknown
• Persistent cough greater than a 3 week duration	◯ Yes	◯ No	◯ Unknown
• Cough that produces blood	◯ Yes	◯ No	◯ Unknown
• If exposed to anyone with tuberculosis	◯ Yes	◯ No	◯ Unknown

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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Dental Information

Do your gums bleed when you brush?	Yes	No	Unknown
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No	Unknown
Does food or floss catch between your teeth?	Yes	No	Unknown
Is your mouth dry?	Yes	No	Unknown
Have you had periodontal (gum) treatment?	Yes	No	Unknown
Have you ever had orthodontic (braces) treatment?	Yes	No	Unknown
Have you had any problems associated with previous dental treatment?	Yes	No	Unknown
Do you drink bottled or filtered water?	Yes	No	Unknown

If yes, how often?

Are you currently experiencing dental pain or discomfort?	Yes	No	Unknown
Do you have earaches or neck pain?	Yes	No	Unknown
Do you have any clicking, popping or discomfort in the jaw?	Yes	No	Unknown
Do you grind or clench your teeth?	Yes	No	Unknown
Do you have sores or ulcers in your mouth?	Yes	No	Unknown
Do you wear dentures or partials?	Yes	No	Unknown
Do you participate in active recreational activities?	Yes	No	Unknown
Have you ever had injuries to your head or mouth?	Yes	No	Unknown
Do you floss?	Yes	No	Unknown

If yes, how often?

How often do you brush your teeth?

Do you use dental aids? (tooth picks, water floss, wooden tips, stimudent)	Yes	No	Unknown

If yes, specify.

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

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Medical Information

Are you under the care of a physician? ◯ Yes ◯ No ◯ Unknown

Physician name: Phone number: ( )

Has there been any change in your health within the past year? ◯ Yes ◯ No ◯ Unknown

If yes, what condition is being treated?

Date of last physical exam:

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No ◯ Unknown

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medication? ◯ Yes ◯ No ◯ Unknown

If yes, please list all, including vitamins, natural and herbal remedies and/or diet supplements:

1. 7.
2. 8.
3. 9.
4. 10.
5. 11.
6. 12.

Do you wear contact lenses? ◯ Yes ◯ No ◯ Unknown

Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow) replacement? ◯ Yes ◯ No ◯ Unknown

Date: If yes, have you had any complications? ◯ Yes ◯ No ◯ Unknown

Are you taking or scheduled to begin taking either of the medications:

Fosamax or Actonel for osteoporosis? ◯ Yes ◯ No ◯ Unknown

Do you use recreational drugs? ◯ Yes ◯ No ◯ Unknown

Do you use tobacco (smoking, snuff, chew)? ◯ Yes ◯ No ◯ Unknown

If yes, how interested are you in stopping? ◯ Very ◯ Somewhat ◯ Not Interested

Do you drink alcoholic beverages? ◯ Yes ◯ No ◯ Unknown

If yes, how much do you typically drink in a week?

WOMEN ONLY: Are you:

Pregnant? ◯ Yes ◯ No ◯ Unknown

If yes, number of weeks:

Taking birth control pills or hormonal replacement? ◯ Yes ◯ No ◯ Unknown

Nursing? ◯ Yes ◯ No ◯ Unknown

Allergies - Are you allergic to or have you had a reaction to:

Local anesthetics	Yes	No	Unknown
Aspirin	Yes	No	Unknown
Penicillin or other antibiotics	Yes	No	Unknown
Barbiturates, sedatives or sleeping pills	Yes	No	Unknown
Sulfa drugs	Yes	No	Unknown
Codeine or other narcotics	Yes	No	Unknown
Metals	Yes	No	Unknown
Latex (rubber)	Yes	No	Unknown
Iodine	Yes	No	Unknown
Seasonal allergies (hay fever)	Yes	No	Unknown
Animals	Yes	No	Unknown
Food	Yes	No	Unknown
Other	Yes	No	Unknown

Please mark your response to indicate if you have or have had any of the following diseases or problems.

Heart disease:

Artificial (prosthetic) heart valve	Yes	No	Unknown
Previous infective endocarditis	Yes	No	Unknown
Heart transplant	Yes	No	Unknown
Congenital heart disease	Yes	No	Unknown
Cardiovascular disease	Yes	No	Unknown
Angina	Yes	No	Unknown
Arteriosclerosis	Yes	No	Unknown
Damaged heart valves	Yes	No	Unknown
Heart attack	Yes	No	Unknown
High blood pressure	Yes	No	Unknown
Pacemaker	Yes	No	Unknown
Mitral valve prolapse	Yes	No	Unknown
Rheumatic heart disease	Yes	No	Unknown
Rheumatic fever	Yes	No	Unknown
Other congenital heart defects	Yes	No	Unknown
Abnormal bleeding	Yes	No	Unknown
Anemia	Yes	No	Unknown
Blood transfusion	Yes	No	Unknown
If yes, date:			
Hemophilia	Yes	No	Unknown
AIDS or HIV infection	Yes	No	Unknown
Arthritis	Yes	No	Unknown
Autoimmune disease	Yes	No	Unknown
Rheumatoid arthritis	Yes	No	Unknown
Systemic lupus erythematous	Yes	No	Unknown

Lung disease:

Asthma	Yes	No	Unknown
Bronchitis	Yes	No	Unknown
Emphysema	Yes	No	Unknown
Tuberculosis	Yes	No	Unknown
Shortness of breath and or chest pain upon exertion	Yes	No	Unknown
Lung cancer	Yes	No	Unknown
Other:			

Gastrointestinal disease:

Persistent heart burn	Yes	No	Unknown
Acid reflux	Yes	No	Unknown
Ulcers	Yes	No	Unknown
Eating disorder	Yes	No	Unknown
Severe or rapid weight loss	Yes	No	Unknown
Other:			

Other medical diseases or problems:

Thyroid problems	Yes	No	Unknown
If yes, please specify:			
Stroke	Yes	No	Unknown
Glaucoma	Yes	No	Unknown
Diabetes Type I	Yes	No	Unknown
Diabetes Type II	Yes	No	Unknown
Epilepsy	Yes	No	Unknown
Hepatitis, Jaundice, or liver disease	Yes	No	Unknown
Fainting spells or seizures	Yes	No	Unknown
Neurological disorders	Yes	No	Unknown
If yes, specify:			
Mental health disorders	Yes	No	Unknown
If yes, specify:			
Sleep disorder	Yes	No	Unknown
Sinus infections	Yes	No	Unknown
Headaches or migraines	Yes	No	Unknown
Sexually transmitted disease	Yes	No	Unknown
Cancer treatment/ Chemotherapy/ Radiation	Yes	No	Unknown

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? Yes No Unknown

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No Unknown

Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature of Patient/ Legal Guardian: Date:

FOR COMPLETION BY DENTIST (Comments):