McFarlane
Family Dental

DATE: ______________________

Medical History Questionnaire

NAME: (LAST) ______________________ PREFERRED NAME: ______________________

(FIRST) ______________________ DATE OF BIRTH: (DD/MM/YYYY) ______________

Please fill out the entire form and ask questions where needed, as it is information required for us to provide you with the best possible dental care. All information provided is strictly confidential, and is protected by doctor-patient confidentiality.

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? ☐ Yes ☐ No ☐ Not Sure/Maybe

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2. When was your last medical checkup? ______________________

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.
☐ Yes ☐ No ☐ Not Sure/Maybe
List of medications: ______________________

____

______________________ Pharmacy Name: ______________________

5. Do you have any allergies? (i.e. medications, seasonal, food products etc.)
Please list them below:

____

____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

____

7. Have you ever been advised against taking any specific type of medication? ☐ Yes ☐ No

____

8. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not sure/Maybe

9. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not sure/Maybe

10. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
☐ Yes ☐ No ☐ Not Sure/Maybe
Are you on any blood thinners? ☐ Yes ☐ No ☐ Not Sure/Maybe Medication name: ______________________
Reason for being on blood thinner: ______________________

11. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe Date of surgery: ______________________

12. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, rheumatoid arthritis, crohn's disease, lupus, radiotheraphy, chemotherapy)? ☐ Yes ☐ No ☐ Not Sure/Maybe

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13. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

14. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

16. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ kidney disease	☐ hepatitis
☐ heart attack	☐ cancer	☐ arthritis	☐ drug/alcohol/cannabis use or dependency	☐ shortness of breath	☐ jaundice
☐ stroke, TIA	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ osteoporosis	☐ liver disease
☐ rheumatic fever	☐ lung disease	☐ diabetes		☐ medications (e.g. Fosamax, Actonel, Prolia)	☐ organ transplant/ medical implant

17. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

18. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease or malignant hyperthermia)?
☐ Yes ☐ No ☐ Not Sure/Maybe

19. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe ☐ packs/day X ________ years

20. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe Would you like sedation? ☐ Yes ☐ No

21. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

22. Is there anything else about your health we should be made aware of?

23. WOMEN ONLY: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST NOTES:

DENTIST NOTE ON PRO-AB:
Reason for Pro-AB's: ________
Discontinue Pro-AB's in: 6mo., 1yr., 2yrs. ________

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X ________________________ ________________________
(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)