LASALLE DENTAL
FAMILY & COSMETIC DENTISTRY

MEDICAL HISTORY

First and Last name (please print) _____

Have you had any changes to your medical history in the past year? Yes O No O

_____

Have you been under the care of a physician in the past 5 years? Yes O No O
When was your last medical exam?

_____

Do you take any prescription medications, over-the-counter medications, vitamins, supplements, alternative preparations? If so, please list (**or attach a list**; please include all supplements/vitamins too): Yes O No O_____

_____

Do you currently smoke? Yes O No O If yes, how many cigarettes per day?_____
Do you smoke anything else (E-cigarette, Marijuana, Pipe)? Yes O No O

Do you drink alcohol? Yes O No O If so, how much per week?_____

Any recreational drug use? Yes O No O

Do you have any allergies? Yes O No O If so, please list and provide us with reaction, and time of last episode._____

Have you had any surgeries or hospitalization? Yes O No O Please indicate:

_____

Are you on blood thinners (e.g. Aspirin, Coumadin/Warfarin, Plavix, Eliquis, Xarelto)? Yes O No O

Have you had any issues with healing or bleeding in the past? Yes O No O

Do you have a congenital heart defect O High blood pressure O Congestive heart failureO

Have you ever had a joint replacement O A valve replacement O Stent replacement O
Infective endocarditis (an infection of the heart) O

Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes O No O

Have you ever been diagnosed with, or do you currently have DIABETES? Yes O No O If so when were you diagnosed?_____ What is your most recent glycosylated haemoglobin (HbA1c)?_____

Have you ever been diagnosed with HIV/AIDS or hepatitis? Yes O No O

Are you taking or have you ever taken any bone altering medications for the treatment of osteoporosis, cancer, etc., either by mouth, injection under the skin, or intravenously? Yes **O** No **O**

If female, are you pregnant or lactating? Yes **O** No **O**

Have you had or been diagnosed with any of the following:

- O Heart attack
- O Jaundice
- O Gout
- O Liver disease
- O Kidney disease/problems
- O bleeding disorder
- O Lung disease
- O Stroke/TIA
- O Thyroid disease
- O Epilepsy
- O Drug/alcohol dependency
- O Chest pain
- O Angina
- O Shortness of breath
- O Tuberculosis
- O Rheumatic fever
- O Heart murmur
- O Mitral valve pro-lapse
- O Anemia
- O Osteoporosis/arthritis
- O Rheumatoid arthritis
- O Lupus
- O High cholesterol
- O Artificial stents
- O Eye problems
- O Sinusitis
- O Gastro esophageal reflux disease
- O Ulcerative colitis or Crohn's disease
- O Asthma
- O Sleep apnea
- O Mental illness

Are there any other conditions you have or may have had in the past which are not listed above? Yes **O** No **O**

_____

Do any of the above conditions run in your family? Yes **O** No **O**_____

_____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE

_____

DDS COMMENTS AND DATED SIGNATURE OF REVIEW

PATIENT INFORMATION

Full Name:_____

Gender: Male **O** Female **O** Birth date:_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____

Business Phone: _____ Occupation: _____

E-mail: _____ OK to e-mail you? Yes **O** No **O**

Family Doctor: _____ Phone: _____

Emergency contact: _____ Relationship: _____

Emergency contact phone number: _____

DENTAL INSURANCE INFORMATION

No dental insurance **O**

	Primary Insurance	**Secondary Insurance**
Insurance company:	_____	_____
Insured's name:	_____	_____
Insured's DOB:	_____	_____
Relationship to insured:	_____	_____
Employer:	_____	_____
Policy number:	_____	_____
Identification number:	_____	_____

DENTAL HISTORY

Have you seen a dentist in the last 3 years? _____

When was your last dental check up/cleaning? _____

Have you had x-rays in the last 3 years? Yes **O** No **O**

Are you happy with the appearance of your teeth? Yes **O** No **O**

Have you ever had any of the following:

Periodontal treatment **O** Orthodontic treatment **O**
Oral surgery **O** Night guard **O**
Removable appliance **O** Dental implants **O**
Trauma to your face or jaws **O**
Temporomandibular disorder (TMJ) **O**

How many times per day do you brush your teeth? _____ Floss your teeth? _____

Do any of your teeth hurt? **O** Feel loose? **O** Have shifted? **O** feel sensitive? **O**

Do your gums bleed? **O** Swell? **O** Hurt? **O**

Do you grind or clench you teeth? _____

Have you ever had any complications during or following dental treatment? Yes **O** No **O**

Do you have any emotional concerns about having dental treatment? Yes **O** No **O**