Medical Questionnaire-Adult

auroradentalcentre
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phone: 905.727.9220

Medical Status

1. What is your medical doctor's name? _____
2. What is your medical doctor's phone number? _____
3. Date of last physical examination? _____
4. Are you currently under a physician's care? ☐ yes ☐ no
5. Do you have frequent headaches? ☐ yes ☐ no
6. Do you smoke? ☐ yes ☐ no
7. Do you drink alcohol? ☐ yes ☐ no
   If yes, how much? _____
8. Do you use recreational drugs? ☐ yes ☐ no

Medications

9. Do you routinely take vitamins, herbal substances, or natural products? ☐ yes ☐ no
10. Are you currently taking birth control medication? ☐ yes ☐ no
11. Are you taking any medications? ☐ yes ☐ no
    If yes, please list ALL medications _____
    _____
    _____
    _____
    _____
12. Are you sensitive or have adverse reactions to Latex? ☐ yes ☐ no ☐ not sure
13. Are you sensitive or have adverse reactions to any Metals? ☐ yes ☐ no ☐ not sure
14. Are you allergic or have adverse reactions to Aspirin? ☐ yes ☐ no ☐ not sure
15. Are you allergic or have adverse reactions to Barbiturates (sleeping pills)? ☐ yes ☐ no ☐ not sure
16. Are you allergic or have adverse reactions to Codeine? ☐ yes ☐ no ☐ not sure
17. Are you allergic or have adverse reactions to Penicillin? ☐ yes ☐ no ☐ not sure
18. Are you allergic or have adverse reactions to Sulfa Drugs? ☐ yes ☐ no ☐ not sure
19. Are you allergic or have adverse reactions to Local Anesthetic (freezing)? ☐ yes ☐ no ☐ not sure
20. Are you allergic or have adverse reactions to Nitrous Oxide? ☐ yes ☐ no ☐ not sure
21. Are you allergic or have adverse reactions to any other drugs? ☐ yes ☐ no ☐ not sure

Medical Conditions

22. Have you ever been treated for or told you have Arthritis? ☐ yes ☐ no ☐ not sure
23. Have you ever been treated for or told you have Asthma? ☐ yes ☐ no ☐ not sure
24. Have you ever been treated for or told you have a Blood Disorder such as Anemia or Leukemia? ☐ yes ☐ no ☐ not sure
25. Have you ever been treated for or told you have Cardiovascular Disease? ☐ yes ☐ no ☐ not sure
26. Have you ever been treated for or told you have Cancer? ☐ yes ☐ no ☐ not sure
27. Have you ever been treated for or told you have Diabetes? ☐ yes ☐ no ☐ not sure
28. Have you ever been treated for or told you have Emphysema? ☐ yes ☐ no ☐ not sure
29. Have you ever been treated for or told you have Epilepsy? ☐ yes ☐ no ☐ not sure
30. Have you ever experienced heavy bleeding? ☐ yes ☐ no ☐ not sure
31. Have you ever been treated for or told you have Glaucoma? ☐ yes ☐ no ☐ not sure
32. Have you ever been treated for or old you have a Heart Murmur? ☐ yes ☐ no ☐ not sure
33. Have you ever been treated for or told you have Hepatitis B? ☐ yes ☐ no ☐ not sure
34. Have you ever been treated for or told you have HIV(AIDS)? ☐ yes ☐ no ☐ not sure
35. Have you ever been treated for or told you have Hypertension? ☐ yes ☐ no ☐ not sure
36. Have you ever had any Joint Replacement? ☐ yes ☐ no ☐ not sure
37. Have you ever been treated for or told you have Liver Disease? ☐ yes ☐ no ☐ not sure
38. Have you ever been treated for or told you have a Mental Disability (by a doctor)? ☐ yes ☐ no ☐ not sure
39. Have you ever been treated for or told you have Renal Disease? ☐ yes ☐ no ☐ not sure
40. Have you ever been treated for or told you have Rheumatic Fever? ☐ yes ☐ no ☐ not sure
41. Have you been treated for or been told you have a Thyroid Disorder? ☐ yes ☐ no ☐ not sure
42. Have you ever been treated for or told you have Tuberculosis? ☐ yes ☐ no ☐ not sure
43. Have you ever been treated for or told you have a Venereal Disease? ☐ yes ☐ no ☐ not sure
44. Is there anything else we should know? _____
    _____
    _____

Additional Information

45. Have you been diagnosed with any disease, condition or problem not listed? _____
    _____
46. Is there anything else about your health we should be aware of?
    _____
    _____
47. Is there a possibility that you are pregnant? If yes, when are you due? _____
48. Do you wish to speak with the doctor privately about any problem or medical condition? ☐ yes ☐ no

I HEARBY CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND HAVE NOT KNOWINGLY OMITTED ANY IMPORTANT INFORMATION REGARDING MY HEALTH, WHICH MAY EFFECT MY SAFETY AND THE SAFETY OF THE DOCTOR AND THE STAFF.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

DOCTOR'S SIGNATURE: _____