CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

CONFIDENTIAL PATIENT INFORMATION:

NAME: _____

DATE OF BIRTH (DAY/MONTH/YEAR): _____ /_____ /_____

HOME ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMAIL: _____

INFORMATION IN CASE OF EMERGENCY:

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

FAMILY DR: _____ CLINIC: _____

LIST MEDICAL SPECIALISTS: SPECIALTY TYPE:

_____ _____

_____ _____

PROVINCIAL HEALTH CARE #: _____ PROV: _____

The following information enables us to provide you with appropriate dental care. All information is protected by legislation in the Alberta Health Information Act. The dentist and/or staff will review the questions and explain any that you do not understand. The entire form will need to be completed and signed.

Height: _____ Weight: _____ ***Updates →*** *Height:* _____ *Weight:* _____ *Height:* _____ *Weight:* _____

1. Provide the Date of your last Medical/Physical Exam and list any changes in your general health in the past year.?
   If No changes, check the box → ☐

2. At which pharmacy/pharmacies do you fill your prescriptions?

3. List all of your prescription medications, non-prescription supplements, and herbal supplements.

4. List Recreational Drug use and/or Cannabis (CBD use is Not Applicable—Only smoked/inhaled/edible/purified THC is Applicable):
   If None, check the box → ☐

   Multiple Daily Use:_____ Daily Use:_____ Weekly Use:_____ Monthly Use:_____

5. Using the categories below, circle and write in any allergies or adverse reactions you have/have had:
   a) medications b) latex rubber products c) injections d) other (e.g. environmental, foods) If None, check the box → ☐

6. How often do you smoke/use chew tobacco/vape nicotine products? If None, check the box → ☐
   Up to ¼ Pack a day *(1-8mg/day)* ☐ ~½ Pack a day *(9-15mg/day)* ☐ ~¾ Pack a day *(16-22mg/day)* ☐

   ~1 Pack a day *(23-28mg/day)* ☐ Specify Packs/Milligrams if more than 1 Pack a day *(more than 28mg/day):* _____

7. List any history of other Lung/Breathing Conditions including: Sleep Apnea, Asthma or COPD (emphysema, chronic bronchitis) with triggers, and frequency of rescue inhaler use, Pulmonary Embolism, Pulmonary Hypertension, or Tuberculosis.
   If None, check the box → ☐

8. List any history of Heart Conditions including: Heart rate or Heart rhythm problems, Blood Pressure problems, Artery Disease, High Cholesterol, Angina, Heart Attack, Heart Bypass, Heart Disease, Heart Failure and/or Stroke.
   If None, check the box → ☐

9. List any abnormalities of the Heart Chambers, Heart Valves; and any history of Heart Valve infection, Heart Valve surgery, or Heart Valve Replacement. If None, check the box → ☐

10. List any history of Blood Diseases including: Anemia, Bleeding disorders (genetic or medication induced), and Clotting disorders.
    If None, check the box → ☐

If you are taking Warfarin/Coumadin, what is your INR testing Frequency? _____

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Update Frequency: ~1y if multiple Med Cond, ~2y if few Med Cond, ~3y if no Med Cond

11. How often do you consume alcohol? *(1 drink = one 355ml can 5% beer = ½ pint/250ml 7% beer = 1½ oz liquor = 5oz/150ml small glass wine)*

None (or fewer than 1 Drink/week) ☐ 1-2 Drinks/week (1-28g) ☐ 3-4 Drinks/week (29-56g) ☐ 5-6 Drinks/week (57-84g) ☐

7-8 Drinks/week (85-112g) ☐ 9-10 Drinks/week (113-140g) ☐ 11-12 Drinks/week (141-168g) ☐ 13+ Drinks/week (168g+) ☐

12. List any history of Liver Disease, Hepatitis or other Liver conditions (including genetic, medication or alcohol induced).

If None, check the box → ☐

Hepatitis B ☐ Hepatitis C ☐ Other: _____

13. Using the categories below, note any history of Diabetes and HbA1c testing. If None, check the box → ☐

Type 1 → ☐ Type 2 → ☐ *What is your HbA1c Testing Frequency?:* _____

14. List any history of Kidney Disease, Digestive/Intestinal Diseases, Stomach Ulcers, Reflux Disease, or Crohn's Disease.

If None, check the box → ☐

15. List any history of Skin Diseases, Arthritis, Bone Diseases, Glaucoma or Other Eye Diseases. If None, check the box → ☐

16. List any history of joint infections and/or prosthetic (artificial) joint surgeries. If None, check the box → ☐

17. List any medical conditions or medical therapies that have affected/could affect your immune system.
e.g.: Leukemia, AIDS, HIV infection, Radiation-therapy, Chemotherapy, Transplant therapy, etc. If None, check the box → ☐

18. Has an antibiotic ever caused you severe/bloody diarrhea, or have you ever been diagnosed with Clostridium Difficile Associated Disease?

YES ☐ NO ☐ NOT SURE/MAYBE ☐

19. Have you ever been told that you, or anyone with whom you have household contact with, have MRSA (methicillin/oxacillin-resistant staph aureus) or VRE (vancomycin-resistant enterococci) or a "superbug"?

YES ☐ NO ☐ NOT SURE/MAYBE ☐

20. Have you ever been diagnosed with a Prion Disease? eg. CJD (Creutzfeld-Jakob-disease), GSS (Gerstmann Straussler-Scheinker syndrome), FFI (Fatal Familial Insomnia)

YES ☐ NO ☐ NOT SURE/MAYBE ☐

21. Check any other Medical Conditions you have/have had that were not noted in the above questions.

❒ Chronic pain	❒ Chronic Pain Reliever Use	❒ Other Autoimmune Disease	❒ Other Inflammatory Disease
❒ Corticosteroid therapy	❒ Osteoporosis/Osteopetrosis	❒ Bisphosphonate Use	❒ Neurological Disease
❒ Seizure Disorder/Epilepsy	❒ Dementia Disorder	❒ Sleeping Pill Use	❒ Depression
❒ Anxiety	❒ Autism Spectrum	❒ ADHD	❒ Other Mental Health Condition
❒ Brain Injury	❒ Spinal cord Injury	❒ Alcohol dependency	❒ Drug dependency
❒ Cancer History	❒ Neuromuscular Disease	❒ Fibromyalgia	❒ Thyroid Disease
❒ Chronic Dry Mouth	❒ Diet Pill Therapy	*Additional Notes:*	

22. How nervous are you during dental treatment? Extreme ☐ Very ☐ Somewhat ☐ Not at All ☐

23. *For Women Only:* Please be sure to notify the Staff if you are breastfeeding or pregnant; and your expected delivery date.

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

Patient/Parent/Guardian/POA Signature: _____ Date: _____ Dr. Initials: ____

(Only to be used for Future Updates) I have noted all changes to the information on this document

Patient/Parent/Guardian/POA Signature: _____ Date: _____ Dr. Initials: ____

Patient/Parent/Guardian/POA Signature: _____ Date: _____ Dr. Initials: ____