Coast DENTAL CENTRE

Medical History

Patient Name: _____ Gender: ☐Female ☐Male ☐Other ☐Prefer not to answer

Guardian's Name (if patient is a minor): _____

Date of Birth M:_____ D: _____Y:_____ Email: _____ Occupation:_____

Home: _____ Mobile: _____ Work (optional): _____

Address including postal code: _____

Family Doctor: _____ Office phone #:_____

Name of emergency contact: _____Phone #:_____

Do you or have you ever had:

Hospitalization for illness or injury: ☐Yes ☐No If yes**,** please provide details: _____

Allergies: ☐Aspirin ☐Ibuprofen ☐Acetaminophen ☐Codeine ☐Penicillin ☐Tetracycline ☐Local anesthetic ☐Metals (nickel, gold, silver) ☐Fluoride ☐Sulfa ☐Erythromycin ☐Latex ☐Other_____ ☐No known allergies

Joint Replacement: ☐Yes ☐No If yes what joint? _____ When? _____

Female: ☐Osteoporosis? ☐Yes ☐No If yes, are you taking medication? ☐Yes ☐No

Select all conditions that apply to you

☐ *Artificial Heart Valves*

☐ *Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits*

☐ *A history of infective endocarditis*

☐ Heart Attack - Date:_____

☐ Cardiac Stent(s) - Date:_____

☐ Stroke - Date:_____

☐ High or Low Blood Pressure

☐ Anemia or other blood disorder

☐ Prolonged bleeding due to slight cut

☐ On blood thinners i.e. Coumadin, Adult Aspirin, Plavix (INR #: _____)

☐ Emphysema

☐ Tuberculosis

☐ Asthma: Do you carry an inhaler with you?

☐ Thyroid Disease

☐ Kidney Disease

☐ Liver Disease

☐ Jaundice

☐ Cancer - Type:_____

☐ Radiation/Chemotherapy

☐ Male Only: Prostate disorders

☐ *A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention within the last six months*

☐ *Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device*

☐ *A cardiac transplant that developed a problem in a heart valve*

☐ Emotional Disorders, Depression, Psychiatric treatment

☐ Epilepsy, convulsion (seizures)

☐ Muscular dystrophy, multiple sclerosis

☐ Neurologic problems (ADD)

☐ Hepatitis - Type:_____

☐ Breathing or Sleep Problems (i.e. snoring, sinus)

☐ Unexplained sore throat, feeling like something is caught in throat or chronic hoarseness

☐ HIV/AIDS

☐ Colitis/Crohns

☐ Eating Disorder (Bulimia, Anorexia Nervosa)

☐ Lupus

☐ Cold Sores

☐ Head or Neck injuries

☐ Lumps or swelling in the mouth or neck area

☐ Digestive disorders (i.e. Gastric reflux)

☐ Drug Dependency - Type:_____

☐ Consumer of alcohol – number of times per week:_____

☐ None applies to me

Any medical condition(s) or impending surgery not listed: ☐Yes ☐No. If yes, please indicate:

List all prescribed **MEDICATIONS** & over-the-counter **SUPPLEMENTS** & **VITAMINS** that you are currently taking.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevalence & severity of gum conditions increases with the following risk factors. In fact, 90% of all systemic diseases have an oral manifestation & gum disease can affect major organs. Eliminating gum disease is especially important to the oral & overall health of the following patients (please indicate which apply):

TOBACCO USE

Current Tobacco User: ☐Yes ☐No If yes, do you want to quit? ☐Yes ☐Contemplation Phase ☐No
What form (cigarettes, pipe, chew, marijuana, e-cigarettes etc.)? _____
How much/day _____ For How Long? _____
Previous Tobacco user: ☐Yes ☐No If yes, when did you quit**?** _____

OTHER SYSTEMIC DISEASES

Diabetes: ☐Yes ☐No What type? ☐Type I ☐Type II.
Date of last HbA1c test: _____. What is your current HbA1c level? _____
(Diabetes control: Good below 7% A1c/140 mg/dL Fair 7-9% A1c/140-220 mg/dL Poor above 9% A1c/>330mg/dL)
Rheumatoid Arthritis: ☐Yes ☐No
Cardiovascular Disease: ☐Yes ☐No If yes, please specify _____

GENETICS

Family History of Gum Disease: ☐Yes ☐No ☐Don't know If yes, who? _____
Family History of Diabetes: ☐Yes ☐No ☐Don't know If yes, who? _____
Family History of Alzheimer's disease: ☐Yes ☐No ☐Don't know If yes, who? _____

STRESS

Is your stress level high? ☐Yes ☐No Are you currently going through any life altering events? ☐Yes ☐No
If yes, what? (optional) _____

OVERWEIGHT

Are you overweight? ☐Yes ☐No Height: _____ Weight: _____

MEDICATIONS

Some drugs can affect your oral health. Are you taking any of the following? ☐Dilantin ☐Ca+ Channel Blockers
☐Immunosuppressant's for organ transplantation ☐Oral contraceptives ☐Anti-depressants

HORMONES

Do any of the following apply? ☐Puberty ☐Pregnant ☐Menopause ☐Post-Menopause ☐Nursing

CLENCHING & GRINDING

Do you clench or grind? ☐Yes ☐No If yes, are you using an ☐Upper nightguard ☐Lower nightguard or ☐None

***** Changes to medical/dental history particularly, related to medications, allergies, recent hospitable visits, and glucose and INR numbers must be updated with your dental professional.***

***** It is contraindicated to treat patients who have not taken their required premedication.***

Dental History

I would rate the condition of my mouth as? ☐Excellent ☐Good ☐Fair ☐Poor
What is your current care regime?
Floss: ☐Yes ☐No If yes, how often?_____
Waterpik: ☐Yes ☐No If yes, how often? _____
Mouth rinse: ☐Yes ☐No If yes, how often? _____
What type of mouth rinse? ☐with alcohol ☐without alcohol ☐with fluoride ☐without fluoride
Tooth Brush: ☐Manual ☐Electric How often?_____
Other home care products: _____

Cosmetics

YES	NO	
☐	☐	Is there anything about the appearance of your teeth that you would like to change?
☐	☐	Have you ever whitened (bleached) your teeth? If no, would you like to? ☐Yes ☐No
☐	☐	Are you interested in Veneers, Crowns, Invisalign (clear braces), Braces, White fillings?

Notes:

Function

☐	☐	Do you have problems chewing gum and/or hard foods?
☐	☐	Are your teeth crowding or developing spaces?
☐	☐	Are there areas in your mouth where food gets trapped?
☐	☐	Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)
☐	☐	Do you wear or have worn a night appliance/ guard or sports guard?

Notes:

Comfort

☐	☐	Do you have any toothaches currently?
☐	☐	Do you avoid brushing any part of your mouth due to pain/discomfort?
☐	☐	Do you experience discomfort with your soft tissues? ie. Lips, cheeks, tongue
☐	☐	Are any of your teeth sensitive to hot, cold, sweets or pressure?

Notes:

Longevity

☐	☐	Do your gums bleed when brushing, flossing, or eating?
☐	☐	Have you ever noticed an unpleasant taste or odour in your mouth?
☐	☐	Do your gums and or teeth hurt during cleanings?
☐	☐	Have you ever had your teeth cleaned with freezing?

Notes:

I, _____ (patient/ guardian name), certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

Patient/ parent/ guardian Signature: _____ Date: _____