Moss Street Healthcare Centre

CONFIDENTIAL HEALTH HISTORY

The following information is requested in order to help the Dentist make a thorough diagnosis.
Also, we strive to be considerate of your time and feelings. Thank you for your cooperation.

Patients Name_____ Date_____

Address_____ Home Phone_____

City & Postal Code_____ Work Phone_____

Email_____ Cell Phone_____

Birth Date (DD/MM/YYYY)_____ Age_____

1. Care Card Number: _____ Status Number:_____

2. Personal physician/family doctor_____ Phone_____

Last visit?_____ For what purpose?_____

3. Have you had any serious illness?_____ If so, what and when?_____

4. Are you now under a physician's care for a particular problem? _____

5. Would you estimate your present health as: good fair poor excellent (circle one)

6. Do you have or have you ever had? (circle yes or no)

A. Rheumatic Fever or Rheumatic Heart Disease?	Y	N
B. Congenital Heart Disease?	Y	N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpations, Heart Surgery, Pacemaker)?	Y	N
D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?	Y	N
E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?	Y	N
F. Bleeding disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?	Y	N
G. Liver Disease (Jaundice, Hepatitis: A, B or C)?	Y	N
H. Diabetes: Type: 1 or 2 (circle one)	Y	N
I. Thyroid Disease (Goiter)?	Y	N
J. Arthritis?	Y	N
K. Stomach Ulcers or Colitis?	Y	N
L. Glaucoma?	Y	N
M. Osteoporosis?	Y	N
N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?	Y	N
O. Radiation (x-ray) treatment for Cancer?	Y	N
P. HIV/AIDS	Y	N
Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?	Y	N
R. Sinus or Nasal Problems?	Y	N
S. Any disease, drug or transplant operation that has depressed your immune system?	Y	N

7. Are you using any of the following?

A. Antibiotics?	Y	N
B. Anticoagulants (Blood Thinners)?	Y	N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Y	N
D. High Blood Pressure medication?	Y	N
E. Steroids (Cortisone, Prednisone, etc)?	Y	N
F. Tranquilizers?	Y	N
G. Insulin or Oral Anti-Diabetic drugs?	Y	N

H. Digitalis, Inderal, Nitroglycerin, or other heart drug? Y N

(Continue On Other Side) →

I. Are you takin Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)? Y N

J. Have you ever been advised not to take a medication? Y N

K. Please List any and all medications currently taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

8. Are you allergic to or have you had an adverse reaction to:

A. Local Anesthesia (Novacain, etc)? Y N
B. Penicillin or other antibiotics? Y N
C. Sedatives, Barbiturates? Y N
D. Aspirin or Ibuprofen? Y N
E. Codeine or other pain killers? Y N
F. Latex or Rubber products? Y N
G. Metal of any kind? Y N
H. Chemicals or jewelry (rash or sensitivity)? Y N
I. Food Products? Y N
J. Other allergies or reactions? Please list Y N

_____

_____

9. Do you smoke or chew tobacco? How many per day? ____ Y N

10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N

11. Have you had any serious problems associated with any previous dental treatment? Y N

12. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N

13. Do you have any other disease, conditions or problem not listed above that you think the doctor should know about? Y N

14. Do you wish to talk to the doctor privately about anything? Y N

15. Have you ever had a bone density scan? Y N

16. ***For Women Only***

A. Are you pregnant, or is there any chance**?** Y N

B. Are you nursing? Y N

C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness or oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance. Y N

17. ***Dental***

Do you have a regular family dentist?_____ Do you receive regular comprehensive care? _____ Last visit to dentist? (Approximate) _____ Purpose: _____

Are you satisfied with dental care received in the past? _____

If no, list things that bothered you so that we may try to avoid them. (High cost may be included)_____

Insurance Information: **Primary Insurance**

Dental Coverage? Yes or No (please circle) Insurance Co. Name:_____

Payment Policy

Payment is due upon completion of treatment. Please note that not all services may be covered by Insurance coverage. It is the patients' responsibility to cover the procedures that are not covered by their Insurance Plan.

_____ _____ _____

Date Patient, Parent or Guardian Signature Doctor's Initials