MEDICAL HISTORY QUESTIONNAIRE

FULL NAME: ______________________________ **DOB:** DD/MM/YYYY

The following information is required to enable us to provide you with the best possible orthodontic care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review the questions and explain any that you do not understand. Please fill out the entire form.

Family doctor's name:______________________________

Date of last medical checkup:______________________________

Is the patient currently under the care of a physician? ❑ YES ❑ NO

If yes, for what reason? ______________________________

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History of major illness or ever hospitalized? ❑ YES ❑ NO

If yes, please describe: ______________________________

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Has the patient been treated for or had any of the following? (please circle)

rheumatic fever	rheumatic heart disease	asthma
autism	diabetes	high blood pressure
tuberculosis	nervous disorder	radiation therapy
arthritis	artificial joint	kidney or liver problems
heart disease	heart murmur	hepatitis
cancer	bleeding problems	epilepsy
HIV positive	sexually transmitted disease	learning disability
osteoporosis	bisphosphonates	
other__________		

Any problems with dental anesthetic, drugs or procedures done by a dentist? ❑ YES ❑ NO

Any sensitivities or allergies? ❑ YES ❑ NO

If yes, please describe: ______________________________

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Currently taking any medications? ❑ YES ❑ NO

If yes, please list (include dosage):______________________________

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Any shortness of breath or pains in the chest? ❑ YES ❑ NO

Any snoring or sleeping problems? ❑ YES ❑ NO

Any family history of snoring? ❑ YES ❑ NO

Do you smoke or chew tobacco products? ❑ YES ❑ NO

For women: *Are you pregnant?* ❑ YES ❑ NO

Are you in good health? ❑ YES ❑ NO

Signature of patient:______________________________

Date:______________________________

Signature of person filling out form:______________________________

Orthodontist's signature:______________________________

DR. KENT FLOREANI , BSc DDS MCID · DR. MICHAEL O'TOOLE , BSc DDS MSc FRCD(C)· DR. CARLY DOOL , DMD MSc FRCD(C)

648 Bay Street Sault Ste. Marie, Ontario P6A 1X8

tel. 705.942.7223 fax. 705.942.7227 email. info@straightsmile.ca

straightsmile.ca