Sandstone Dental
Perfecting One Smile at a Time

Adult Health History Questionnaire

For Office Use:

1. Patient Information

Last Name: _____ First Name: _____ DOB: _____ / _____ / _____ Gender: _____
(day / month / year)

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Business: _____ Cell: _____

Email Address: _____ Preferred Method of Contact: _____

How did you hear about Sandstone Dental: _____

Family Doctor: _____ Phone Number: _____

Medical Specialist: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Your safety and optimal oral health are our priorities. The following information enables us to provide you with the best oral health care services safely and effectively. **Please complete this entire form.** During your visit you will be asked questions regarding your questionnaire responses. All information is confidential and treated in accordance with applicable provincial and federal privacy legislation.

What is the reason for your visit today?:

2. Dental Health

1. When was your last dental check up?	3. When were your last dental x-rays?
2. When was your last dental cleaning?	4. How often do you brush? Floss?

Please check Yes or No for the following:	Yes	No		Yes	No
5. Do your gums bleed?			10. Do you suffer frequent headaches?		
6. Have you ever had orthodontic treatment/braces?			11. Do you have a removable dental appliance?		
7. Are your teeth sensitive to touch, temperature, or sweets?			12. Do you have dental implants		
8. Have you ever had periodontal (gum) surgery or treatment?			13. Do you have a dry mouth?		
9. Have you ever had a head and / or neck injury?			14. Are you nervous during dental treatment?		

Please Explain in Detail all Yes Answers:

3. Health History

1. When was your last medical visit? Reason:

Please check Yes or No for the following:	Yes	No		Yes	No
2. Have you had any changes to your health or any treatment for medical concerns in the past year?			5. Have you ever had a peculiar or adverse reaction to any medications or injections?		
3. Have you ever been hospitalized for any illness or operation?			6. Do you have any allergies or sensitivities?		
4. Have you ever been advised to take antibiotics before dental treatment?			7. Women: Are you or could you be pregnant, or are you breastfeeding.		

Please Explain in Detail all Yes Answers:

8. Please list all medications you are taking, including prescription, over the counter, and natural health products		
Drug Name	Amount, Dose, Frequency	Reason

Do you or have you had any of the following?

Cardiovascular / Respiratory	Yes	No	Endocrine / Digestion	Yes	No
1. Angina / Coronary artery disease			1. Diabetes, what type?		
2. Heart valve problems or artificial heart valves			2. Thyroid / Parathyroid disease		
3. Congenital heart defects			3. Eating disorder		
4. Heart disease			4. Dietary restrictions		
5. Chest pain			Gastrointestinal / Urinary		
6. Heart attack			1. Hepatitis / Jaundice / Liver Disease		
7. Heart murmur			2. Acid reflux / Heart burn		
8. High or low blood pressure			3. Stomach ulcers		
9. Congestive heart failure			4. Kidney disease		
10. High or low cholesterol			Neurological / Muscular Skeletal		
11. Heart surgery / Transplant			1. Stroke		
12. Pacemaker			2. Seizure disorder / Epilepsy		
13. Rheumatic fever / heart disease / Infective endocarditis			3. Mental health disorder		
14. Shortness of breath			4. Arthritis / Rheumatoid arthritis		
15. Swollen ankles			5. Osteoporosis		
16. Asthma			6. Joint replacement		
17. Tuberculosis			Other		
18. Sinus problems			1. Do you use tobacco products?		
19. Chronic cough / new cough			2. Do you have a drug / alcohol dependency?		
20. Emphysema / Chronic bronchitis			3. Do you have any vision or eye problems?		
21. Do you snore?			4. Have you had any recent changes to your weight?		
22. Do you have a sleeping disorder? (sleep apnea)			Please explain in detail all Yes answers:		
Immune System / Infectious Diseases					
1. HIV / AIDS					
2. Systemic lupus erythematous					
3. Other conditions that effect immune system (steroid therapy, Epstein bar, chemotherapy / radiation, cancer, sarcoidosis)					
4. Sexually transmitted infections (e.g. herpes)					

Do you have any other comments, questions, concerns or special needs that may affect your dental treatment?

By signing below, I agree all of the above information is correct to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

Reviewed by (DDS): _____ Date: _____

Office Use Only:

Blood Pressure:	Pulse:	Sp02:	ASA: