For Office Use:

Sandstone Dental

Perfecting One Smile at a Time

Patient Information and Health History Questionnaire

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. Preferred Name:	Date of Birth: _____ / _____ / _____ (year / month / day)
Last: First: Middle:	Age:
Address (Home):	Home Phone:
City: Postal Code:	Cellular Phone:
Occupation: Employer:	Email:
Preferred Method of Contact: ❑ Home Phone ❑ Cell Phone ❑ Email ❑ Text	
How did you find out about our office:	
Please list other family members who are also patients:	

In case of emergency, we should notify: Name:		Relationship:	Phone:
Family Doctor:	Phone:	Medical Specialist:	Phone:
Other Health Provider:	Area of Speciality:	Phone:	

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.

A. DENTAL INFORMATION

1. Do your gums bleed when you brush?	Y	N
2. Have you ever had orthodontic treatment (e.g., braces)?	Y	N
3. Have you ever had any periodontal (gum) treatment?	Y	N
4. Are your teeth sensitve to hot, cold, sweets, or pressure?	Y	N
5. Have you ever had an injury to your head, face, or jaws?	Y	N
6. Do you suffer from frequent headaches?	Y	N
7. Do you have earaches or neck pains?	Y	N
8. Do you have removable dental appliances? Implants?	Y	N
9. Are you nervous during dental treatment?	Y	N

10. What is the reason for your visit?:

11. Date of last dental examination:

12. Date of last hygiene therapy:

13. Date of last dental x-rays:

Please explain YES to any answers:

B. GENERAL INFORMATION

1. Date of last medical checkup:		
2. Are you being treated for any medical condition or have you been treated within the last year?	Y	N
3. Has there been any change in your general health in the past year?	Y	N
4. Have you ever been hospitalized for any illnesses or operations?	Y	N
5. Do you have a prosthetic or artificial joint (e.g., hip, knee)?	Y	N
6. Have you ever been advised to take antibiotics before dental treatment?	Y	N
7. Have you ever had a peculiar or adverse reaction, including allergies, to any medications or injections?	Y	N
8. Do you have any allergies to any foods or materials (e.g., latex or metals)?	Y	N
9. Do you have any allergies (e.g., hay fever, animals)?	Y	N
10. Cancer?	Y	N
11. Dry Mouth?	Y	N

Do you have or have you ever had:

12. Ear or hearing problems?	Y	N
13. Eye problems (e.g., require corrective lenses, glaucoma)?	Y	N

Women:

15. Are you taking oral contraceptives?	Y	N
16. Are you or could you be pregrant? If yes, expected delivery date:	Y	N
17. Are you breastfeeding?	Y	N
18. Are you taking hormone replacement therapy?	Y	N

Please explain any YES answers:

18. Are you taking medications of any kind? Include prescribed drugs (e.g., anticoagulants, drugs for osteoporosis), over-the-counter medications (e.g., daily aspirin, cold and flu remedy), and natural health products (e.g., vitamins, herbal, and diet supplements). If yes, please list.

Drug Name	**Amount, Dose, Frequency** (e.g., One 80mg tablet 3 times per day)	**Reason**	**Date Prescribed and Prescriber**

C. CARDIO/RESPIRATORY

Do you have or have you ever had:		
1. Cardio Vascular Diseases? If yes, specify below:	Y	N
❑ Angina ❑ Arteriosclerosis ❑ Artificial heart valves ❑ Congenital heart defects ❑ Congestive heart failure ❑ Coronary artery disease ❑ Damaged Heart Valves	❑ Heart Attack ❑ Heart Murmur ❑ High or low blood pressure ❑ High or low cholesterol ❑ Mitral valve prolapse ❑ Pacemaker/defibrillator ❑ Rheumatic heart disease/fever	
2. Chest pains upon exertion?	Y	N
3. Shortness of breath?	Y	N
4. Asthma?	Y	N
5. Chronic bronchitis or emphysema?	Y	N
6. Tuberculosis?	Y	N
7. A persistent cough for more than 3 weeks?	Y	N
8. Cough that produces blood?	Y	N
Please explain any YES answers:		

D. ENDOCRINE/DIGESTIVE

Do you have or have you ever had:		
1. Malnutrition?	Y	N
2. Eating Disorder?	Y	N
3. Dietary restrictions (self-imposed or doctor prescribed)	Y	N
4. Night Sweats?	Y	N
5. Slow healing or recurrent infections?	Y	N
6. Thyroid or parathyroid disease?	Y	N
7. Diabetes? If yes, indicate type:	Y	N
Please explain any YES answers:		

E. GASTEROINTESTINAL/GENITOURINARY

Do you have or have you ever had:		
1. Hepatitis, jaundice, or liver disease?	Y	N
2. Difficulty swallowing?	Y	N
3. G.E reflux/persistent heartburn?	Y	N
4. A stomach ulcer?	Y	N
5. Gall bladder problems?	Y	N
6. Kidney or bladder trouble?	Y	N
7. Excessive urination?	Y	N
Please explain any YES answers:		

F. HEMATOLOGIC

Do you have or have you ever had:		
1. Prolonged or abnormal bleeding with simple cut or following surgery, extraction, or an accident?	Y	N
2. A blood transfusion? If yes, date:	Y	N
3. A tendency to bruise easily?	Y	N
4. Any blood disorder (e.g., anemia or hemophilia)?	Y	N
Please explain any YES answers:		

G. NEUROLOGICAL/MUSCULOSKELETAL

Do you have or have you ever had:		
1. A Stroke?	Y	N
2. Convulsions or seizures (e.g., epilepsy)?	Y	N
3. Mental Health Disorders?	Y	N
4. Arthritis?	Y	N
5. Osteoporosis or osteopenia?	Y	N
6. Chronic pain?	Y	N
Please explain any YES answers:		

H. IMMUNE SYSTEM/INFECTIOUS DISEASES

Do you have or have you ever had:		
1. Systematic lupus erythematosus?	Y	N
2. Painful swollen joints or rheumatoid arthritis?	Y	N
3. HIV/AIDS?	Y	N
4. Other diseases or conditions that affect your immune system (e.g., sarcoidosis, Epstein-Barr, radiotherapy, chemotherapy, steroid therapy)?	Y	N
5. Sexually transmitted diseases (e.g., herpes)?	Y	N
6. Have you ever had an antibiotic resistant infection (e.g., MRSA)?	Y	N
Please explain any YES answers:		

I. AIRWAY

Do you have or have you ever had:		
1. Sinus trouble or nasal congestion?	Y	N
2. Tonsils removed?	Y	N
3. Adenoids removed?	Y	N
4. Have you been told that you snore?	Y	N
5. Are you often tired during the day?	Y	N
6. Do you know if you stop breathing, or has anyone witnessed you stop breathing while you are asleep?	Y	N
8. Have you been diagnosed with a sleep disorder?	Y	N
Please explain any YES answers:		

J. OTHER

1. Do you smoke, chew, or snort tobacco products?	Y	N
If yes: Frequency (daily, weekly)?:		
Number of years use?:		
Have you ever tried to quit?	Y	N
Are you interested in quitting?	Y	N
2. Do you have a drug or alcohol dependency?	Y	N
3. Other diseases or medical problems that run in your family?	Y	N
4. Other conditions or medical problems not listed?	Y	N
5. Other special needs that will affect your dental care?	Y	N
Please explain any YES answers:		

Do you have any other comments, questions, or concerns?

To the best of my knowledge, the above information is correct.

Patient's (or Parent's/Guardian's) Signature: _____ Date: _____

Reviewed By: _____ (DDS, RDH) Date: _____

For Office Use:

Height:	Weight:	Blood Pressure:	Pulse:
SpO2:	BMI:	Neck Circumference:	
ASA:		Mental-Thyroid Distance:	
Cervical Range of Motion:		Lungs/Heart Sound:	