North York Dental
DR. ELI SHEM-TOV

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME (MR./MISS/MRS./MS./DR.):

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

PHONE (BUS.):

PHONE (CELL):

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

EMPLOYER NAME:

INSURANCE COMPANY:

POLICY GROUP NUMBER: DIVISION:

CERTIFICATE OR ID NUMBER:

RELATIONSHIP TO INSURED:

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

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If yes, please list using the categories below: ☐ YES ☐ NO ☐ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma/respiratory problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? If yes, please specify. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

- ☐ chest pain, angina
- ☐ heart attack
- ☐ stroke
- ☐ shortness of breath
- ☐ rheumatic fever
- ☐ mitral valve prolapse
- ☐ heart murmur
- ☐ pacemaker
- ☐ lung disease
- ☐ tuberculosis
- ☐ cancer
- ☐ steroid therapy
- ☐ diabetes
- ☐ stomach ulcers
- ☐ arthritis
- ☐ seizures (epilepsy)
- ☐ kidney disease
- ☐ thyroid disease
- ☐ drug/alcohol dependency
- ☐ osteoporosis medications (e.g. Fosamax, Actonel)
- ☐ mental/nervous problems

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please specify. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (i.e. diabetes, cancer or heart disease) If yes, please specify. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Name of prior dentist?

21. How often do you see your dentist? ☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ YEARLY ☐ OTHER

22. Date of last dental visit? Date of last cleaning? Date of last x-rays?

23. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

PLEASE READ BEFORE SIGNING

ACKNOWLEDGEMENT AND CONSENT

I have answered the above questions and health history to the best of my knowledge. I understand that at each dental visit, planned procedures will be clearly explained before treatment is begun. On this basis, I give Dr. Shem-Tov my consent to perform any needed dental treatment, including the use of local anaesthetic as needed.

I understand that my dental insurance plan is a contract between the insuring company and me; and not between the insuring company and my dentist. I also understand that my insurance policy may not cover all treatment and that it is my responsibility to check the terms of my individual insurance policy.

I agree that I am solely responsible for the payment of fees on the day treatment is provided. If I have any questions regarding insurance plans, fees or methods of payment, I understand that your Office Manager is available to explain your policies to me.

I authorize the release of my personal information to my insuring company and/or plan administrator, in order for my claims to be transmitted.

Signature _____ Date _____