ST. JACOBS DENTAL care

Welcome to our office. Please fill out your **MEDICAL HISTORY QUESTIONNAIRE**

Name:____

Date of Birth:______/_______/_________ (DD/MM/YYYY)

Address:____

_________________________ PC: ______________

Home Phone:____

Cell phone:____

Email:____

Employer:____

Address:____

____

Phone:____

Who referred you to our office:

____

Emergency contact information:

Name:____

Relationship:____

Day-time phone:______________________________________

Family doctor:____

Phone:____

Address:____

____

Name of specialist doctor:______________________________

Area of specialty:_____________________________________

Phone:____

Address:____

____

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 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

   ____

2. When was your last medical check-up: ____
3. Has there been any change in your general health in the past year? If yes, please explain ❑ Yes ❑ No ❑ Not Sure

   ____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list ❑ Yes ❑ No ❑ Not Sure

Medication	Reason	Medication	Reason

5. Do you have any allergies? If yes, please list below: ❑ Yes ❑ No ❑ Not Sure

   ____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain ❑ Yes ❑ No ❑ Not Sure

   ____

7. Do you have or have you ever had asthma? ❑ Yes ❑ No ❑ Not Sure
8. Do you have or have you ever had any heart or blood pressure problem? ❑ Yes ❑ No ❑ Not Sure
9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ❑ Yes ❑ No ❑ Not Sure
10. Do you have a prosthetic or artificial joint? ❑ Yes ❑ No ❑ Not Sure
11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ❑ Yes ❑ No ❑ Not Sure

FLIP OVER FOR PAGE 2

12. Do you have any conditions or therapies that could affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) ❑ Yes ❑ No ❑ Not Sure
13. Have you ever had hepatitis, jaundice or liver disease? ❑ Yes ❑ No ❑ Not Sure
14. Do you have a bleeding problem or bleeding disorder? ❑ Yes ❑ No ❑ Not Sure
15. Have you ever been hospitalized for any illnesses or operations in the last 2 years? If yes, please explain. ❑ Yes ❑ No ❑ Not Sure

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

❑ Stroke	❑ Pace maker	❑ Steroid therapy	❑ Kidney disease	❑ Cancer
❑ Heart attack	❑ Lung Disease	❑ Diabetes	❑ Thyroid disease	❑ Arthritis
❑ Chest pain, angina	❑ Tuberculosis	❑ Stomach ulcers	❑ Diet pill therapy	❑ Seizures (epilepsy)
	❑ Shortness of breath	❑ Prosthetic heart valve	❑ Drug/alcohol dependency	

17. Are there any conditions or diseases not listed above that you have or have had? If so what? ❑ Yes ❑ No ❑ Not Sure

    ____
18. Do you smoke or chew tobacco products? ❑ Yes ❑ No ❑ Not Sure
    If so, how often per day________How many years?_____
19. Are you nervous during dental appointments? ❑ Yes ❑ No ❑ Not Sure
20. **For women only**: Are you breast feeding or pregnant? If pregnant, expected due date:______________________ ❑ Yes ❑ No ❑ Not Sure

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

Patient/Parent/Guardian signature:__________________________________Date:__________________________

Dentist Signature:____Date:__________________________

____

Personal Health Information Protection Act

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance. Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA. You may with draw your consent for use of disclosure of your personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my personal health information, and the steps your office is taking to protect my information. I agree that Nusaputra Dentistry Professional Corporation operating as **St. Jacobs Dental Care** can collect, use and disclose personal health information as set out above in the information about the office's privacy policies.

Date:____

Print Name:____

Signature:____

Signature of witness:_____________________________________