MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME:

_____

DATE OF BIRTH (DAY/MO/YR): / /

_____

ADDRESS (HOME):

_____

_____

PHONE (HOME):

_____

PARENT OR LEGAL GUARDIAN NAME:

_____

PHONE (WORK and/or CELL):

_____

EMAIL:

_____

SASK. HOSPITALIZATION NUMBER:

_____

FIRST CANADIAN HEALTH NO. (IF APPLICABLE):

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS:_____

We require the following information to provide your child/charge with the best possible dental care. All information is strictly private, and is protected in accordance with the HIPAA privacy act. Please fill the entire form to the best of your ability. The dentist will review the form with you in greater detail.

Why is your child/charge here today? _____

Any allergies? If so what? _____

Any medications? If so what? _____

When was your child/charge's last medical checkup? _____ Last dental checkup? _____

Does your child/charge have or has he/she ever experienced any of the following? Check all that apply

Asthma	Cancer	Liver Disease	General Anesthesia
Sleep Apnea/Snoring	Bleeding Disorder	Jaundice	Dental Trauma
Tuberculosis	Thyroid Condition	Stroke	MRSA
Pneumonia/Bronchitis	Stomach Ulcers	HIV/AIDS	Hearing Disorder
Anemia	Gastric Reflux	Brain injury	Eye Disorder
Seizures	Diabetes	Abuse/Neglect	ADHD
Heart Condition	Kidney Disease	Hospitalization	

Does your child/charge have any other medical, psychiatric or developmental condition we should know about?

Please list: _____

Are your child's immunizations up to date? ☐ Yes ☐ No

How does your child/charge cope in new situations? ☐Withdraws ☐Warms up ☐Flexible/Extroverted ☐Cries

Does your child/charge have any habits? ☐ thumb/finger sucking ☐ lip/fingernail biting ☐ pacifier ☐ other?

Is your child/charge: ☐breast feeding ☐bottle feeding ☐drinking from sippy-cup?

Frequency of snacks per day? ☐2x/day ☐3 timex/day ☐more than 3x/day

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

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____