ADULT HEALTH QUESTIONNAIRE

The following information is required to thoroughly diagnose and treat any condition and for us to give you the highest possible standard of professional services. All information will be kept strictly confidential. Please ask us for assistance if you do not understand something on this questionnaire.

PERSONAL INFORMATION

Name _____ Usually Called _____ M/F _____

Home Address _____ Date of Birth _____

City _____ Prov. _____ Postal Code _____

Phone #: Res: _____ Bus: _____ Cell: _____

AHC# _____ Email Address _____

Referred by _____

MEDICAL HISTORY

	Y	N
1. Have you ever been hospitalized for a serious illness or surgery? _____	❑	❑
Please specify _____		
2. Were there any complications? Please specify _____	❑	❑
_____		
3. Are you currently under the care of a physician? Reason _____	❑	❑
4. Have you had a medical examination in the last year? _____	❑	❑
Please specify _____		
5. Are you currently taking any prescription or non-prescription medications? _____	❑	❑
Please specify _____		
6. Do you have any allergies? Please specify _____	❑	❑
7. Have you ever had an allergic or adverse reaction to any medications? _____	❑	❑
Please specify _____		
8. To the best of your knowledge have you come in contact with the AIDS virus? _____	❑	❑

9. Have you ever had any of the following diseases or problems?

❑ Heart Murmur	❑ Fainting Spells	❑ Tuberculosis
❑ Rheumatic Fever	❑ Liver Disorder	❑ Bone Disorders
❑ Swollen Ankles	❑ Diabetes	❑ Cancer
❑ Blood Pressure Disorder	❑ Jaundice	❑ Radiation Therapy (cobalt)
❑ Blood Disorder	❑ Hepatitis A B C Other (Circle)	❑ Corticosteroid Therapy
❑ Angina	❑ Kidney Disorder	❑ Steroid Therapy
❑ Heart Attack	❑ Thyroid Disorder	❑ AIDS (acquired immune Deficiency Syndrome)
❑ Heart disease	❑ Stomach/Intestinal disorder	❑ ARC (AIDS related Complex)
❑ Easily breathless	❑ Ulcer	❑ Venereal Disease
❑ Bleed Abnormally	❑ Lung Disorder	❑ Herpes
❑ Blood Transfusion	❑ Asthma	❑ Other

10. Women Only. Are you pregnant? (If so , what month) _____

11. General Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please see reverse side

DATE: / /

DENTAL HISTORY

Y N

1. Have you ever been under the regular care of a dentist? _____ ❑ ❑
2. When was your last dental visit? _____
3. It is the policy and objective of this office to emphasize preventative dentistry.

   Do you agree with this approach? _____
4. Are you interested in learning how to take care of your mouth? _____ ❑ ❑

   (Preventative maintenance) _____
5. Do you wear full or partial dentures? _____ ❑ ❑

   How old are they? _____

   Date of last reline? _____
6. Have you ever had an adverse reaction to dental freezing? _____ ❑ ❑

   Specify _____
7. Are you experiencing any of the following?

- ❑ Unpleasant Odour or Taste in Your Mouth
- ❑ Gums Bleed when Brushing a Flossing
- ❑ Swollen or Tender Gums
- ❑ Loose Teeth
- ❑ Food Catching Between Your Teeth
- ❑ Jaw/Joint Problem
- ❑ Difficulty Opening Jaw
- ❑ Loose Dentures
- ❑ Repaired Denture
- ❑ Teeth Sensitive to Hot, Cold, Pressure, Sweets (please circle)

8. if you were going to change anything about your mouth, what would you it be? _____

_____

9, Describe in your own words your present dental problems _____

_____

OFFICE POLICY

We require immediate payment for services rendered.

CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advicable (including the use of general or local aneathetics as indicated). I will assume responsibility for all fees associated with all procedures.

Patient's Signature _____ Date _____