Dr. Nick Seddon, DMD, FICOI
Cosmetic, Implant, and General Dentistry

Medical History Questionnaire

For the following questions, check YES or NO, whichever applies. You answers are for our records only, and will be confidential.

DATE: _____

NAME: _____ Birthdate: _____

THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH

Sex: _____ Height: _____ Weight: _____ Race: _____

General Medical History:

1. Are you in good general health? ☐ Yes ☐ No
2. Has there been ANY changes in your general health in the past year? ☐ Yes ☐ No
3. My last physical exam was on, approximate date: ☐ Yes ☐ No
4. Are you PRESENTLY under a physician's care? ☐ Yes ☐ No
   a. If YES, what condition? .....
   b. Physician name and address: .....
5. Have you had any serious illnesses or operations? ☐ Yes ☐ No
   a. If YES, please list: .....
6. Have you ever been hospitalized in the past 5 years? ☐ Yes ☐ No
   a. If YES, reason: .....

Cardiovascular System:

7. Do you have or have you had any of the following: Please check:

☐ Heart trouble ☐ Heart attack ☐ Coronary insufficiency ☐ Mitral Valve Prolapse
☐ Stroke ☐ Damaged heart valves ☐ Congenital heart disease

8. Rheumatic heart disease, heart murmur? ☐ Yes ☐ No
9. Chest pain after exertion? ☐ Yes ☐ No
10. Shortness of breath after mild exercise? ☐ Yes ☐ No
11. Do you ankles swell? ☐ Yes ☐ No
12. Do you use extra pillows to sleep? ☐ Yes ☐ No
13. Do you have a cardiac pacemaker? ☐ Yes ☐ No
14. Do you have any blood pressure problems? ☐ Yes ☐ No
    a. If YES, ☐ High ☐ Low

Dundarave Dental Clinic
2461 Bellevue Avenue, West Vancouver, B.C. V7V 1E1
O: (604) 922-0144 • C: (778) 840-0762 • F: (604) 926-4015
W: www.DrNickSeddon.com • E: drseddon@dundaravedental.ca

Central Nervous System:

15. Do you have or have you ever had:
    a. Epilepsy? ☐ Yes ☐ No
    b. Fainting spells? ☐ Yes ☐ No
    c. Seizures? ☐ Yes ☐ No
    d. Emotional disturbances? ☐ Yes ☐ No
16. Do you follow any treatment for a nervous disease? ☐ Yes ☐ No

Respiratory System:

17. Do you have a persistent cough or cold? ☐ Yes ☐ No
18. Do you have or have you ever had tuberculosis? ☐ Yes ☐ No
19. Is there ANY history of tuberculosis in your family? ☐ Yes ☐ No
20. Do you have sinusitis or sinus trouble? ☐ Yes ☐ No
21. Do you have emphysema, chronic bronchitis, asthma? ☐ Yes ☐ No

Digestive System:

22. Do you have ANY stomach ulcers? ☐ Yes ☐ No
23. Do you have or have you ever had:
    a. Acid reflux (GERD)? ☐ Yes ☐ No
    b. Hepatitis? ☐ Yes ☐ No
    c. Jaundice? ☐ Yes ☐ No
    d. Liver disease? ☐ Yes ☐ No
    e. Have you ever vomited blood? ☐ Yes ☐ No
    f. Do you have ANY diarrhea? ☐ Yes ☐ No

Endocrine System:

24. Do you have diabetes? ☐ Yes ☐ No
    a. If YES, is it ☐ Controlled ☐ Uncontrolled
25. Does anyone in your family have diabetes? ☐ Yes ☐ No
26. Do you urinate more than six times per day? ☐ Yes ☐ No
27. Are you thirsty very often or do you have a dry mouth? ☐ Yes ☐ No
28. Do you have hypo or hyperthyroidism ☐ Yes ☐ No

Hematogenous System:

29. Do you have anemia, sickle-cell disease, blood disorder? ☐ Yes ☐ No
30. Is there ANY family history of blood disorders? ☐ Yes ☐ No
31. Are you hemophilic? ☐ Yes ☐ No
32. Have you had abnormal bleeding after any surgery or trauma? ☐ Yes ☐ No
33. Have you ever had a blood transfusion? ☐ Yes ☐ No
34. Immunodeficiency problem? ☐ Yes ☐ No

Allergies:

35. Are you allergic to or have you had reacted adversely to:
    a. Local anesthetic? ☐ Yes ☐ No

b. Antibiotics, penicillin, sulfa drugs? ☐ Yes ☐ No
c. Barbiturates, sedatives, or sleeping pills? ☐ Yes ☐ No
d. Aspirin? ☐ Yes ☐ No
e. Iodine? ☐ Yes ☐ No
f. Codeine or other narcotics? ☐ Yes ☐ No
g. Latex? ☐ Yes ☐ No
h. Others? Please specify .....

36. Do you have asthma, hayfever, or seasonal allergies? ☐ Yes ☐ No
37. Do you have or have you ever had hives or a skin rash? ☐ Yes ☐ No

Urinary System:

38. Do you have or have you ever had:
    a. Kidney trouble? ☐ Yes ☐ No
    b. Dialysis? ☐ Yes ☐ No
    c. Syphilis, gonorrhea? ☐ Yes ☐ No

Bones and Joints:

39. Do you have or have you ever had:
    a. Arthritis? ☐ Yes ☐ No
    b. Inflammatory rheumatism? ☐ Yes ☐ No
    c. Bone infection? ☐ Yes ☐ No
    d. Osteoporosis? ☐ Yes ☐ No
    e. Artificial joint replacement? ☐ Yes ☐ No
40. Have you received or are you currently receiving intravenous medication known as bisphosphonates such as Zomata IV (zoledronic acid) or Aridia IM (pamidronate) ☐ Yes ☐ No
41. Have you received or are you currently receiving oral medication known as bisphosphonates for osteoporosis or another medical condition such as Fosamax (alendronate), Actonal (risedronate), or Boniva (ibandronate sodium) ☐ Yes ☐ No
42. If YES for either 40 or 41:
    a. Have you noticed any changes in your mouth or jaws? ☐ Yes ☐ No
    b. Have you had any jaw pain or toothache? ☐ Yes ☐ No
    c. Have you noticed any foul smell, swelling, or discharge? ☐ Yes ☐ No

Other:

43. Do you have or have you ever had:
    a. Tumor or malignancy? ☐ Yes ☐ No
    b. Chemotherapy or radiation therapy? ☐ Yes ☐ No
44. Do you have or have you ever had ANY condition, disease, or problem not listed above? ☐ Yes ☐ No
    a. If YES, please explain .....
45. Are you regularly exposed to x-rays or any other radiation or toxic substances? ☐ Yes ☐ No
46. Do you have glaucoma? ☐ Yes ☐ No
    a. If YES, ☐ Wide ☐ Close
47. Are you wearing or do you wear contact lenses? ☐ Yes ☐ No
48. Do you drink alcohol? ☐ Yes ☐ No
    a. If YES, how much and how often? .....
49. Do you use tobacco? .....

a. If YES, what kind (cigarettes, oral), how much, and how often? ……

Medications:

50. Are you taking any of the following medications:
    a. Anticoagulants, blood-thinning agents? …… ☐ Yes ☐ No
    b. Medicine for high blood pressue? …… ☐ Yes ☐ No
    c. Tranquilizers? …… ☐ Yes ☐ No
    d. Iodine? …… ☐ Yes ☐ No
    e. Aspirin? …… ☐ Yes ☐ No
    f. Codeine or other narcotics? …… ☐ Yes ☐ No
    g. Steroids? …… ☐ Yes ☐ No
    h. Other? …… ☐ Yes ☐ No
        i. If YES, please explain: ……

Medication List:

Name/Type of Drug	*Dosage*	*How many times per day?*

Women:

51. Are you pregnant? …… ☐ Yes ☐ No
52. Are you nursing? …… ☐ Yes ☐ No
53. Do you have any problems associated with you menstrual period? …… ☐ Yes ☐ No
54. Are you taking oral contraceptives? …… ☐ Yes ☐ No
55. Are you undergoing hormonal therapy? …… ☐ Yes ☐ No

Dental History:

1. What is your chief dental complaint? ……
2. Are you experiencing any pain or discomfort at this time? ……
3. Are you satisfied with the appearance of your teeth? ……
4. Are you able to eat and chew foods satisfactorily? ……
5. Do you have headaches, ear aches, or neck pain? ……
6. Do you frequently experience sinus problems? ……
7. Have you had ANY serious trouble associated with ANY previous dental treatment? ……
    a. If YES, please explain: ……
    ……
    ……

To the best of my knowledge the in formation in this form is accurate.

Signature of patient or guardian	Date
Signature of witness	Date
Dr. Nick Seddon	Date