Fresh Mobile Dental Hygiene

# Health History Questionnaire

info@freshmobiledentalhygiene.ca

| | | | |
|---|---|---|---|
| ❑Mr. ❑Mrs. ❑Miss ❑Ms. ❑Dr. | | | Date of Birth: ____ / ____ / ____ (Year / Month / Day) |
| Last: | First: | Middle: | |
| Address (Home): | Phone: | | Occupation: |
| City: | Postal Code: | | Business Phone: |
| Height: | Weight: | Blood Pressure: | Pulse: / Resp: |

| | | | | | |
|---|---|---|---|---|---|
| **In case of emergency, we should notify:** | Name: | | Relationship: | Phone: | |
| Family Doctor: | Phone: | | Medical Specialist: | Phone: | |
| Other Health Provider: (e.g., Occupational Therapist, Dietitian, Naturopath, Chiropractor) | Area of Specialty: | | Address/Phone: | | |

Your safety and optimal oral health are our priorities. The following information enables us to provide you with the best oral health care services safely and effectively. **Please complete the entire form.** During your visit, you will be asked questions regarding your questionnaire responses. All information is confidential and treated in accordance with applicable provincial and federal privacy legislation.

## A. DENTAL INFORMATION

| | | |
|---|---|---|
| 1. Do your gums bleed when you brush? | Y | N |
| 2. Have you ever had orthodontic or orthotropic treatment (e.g., braces)? | Y | N |
| 3. Have you had any periodontal (gum) treatment? | Y | N |
| 4. Are your teeth sensitive to hot, cold, sweets, or pressure? | Y | N |
| 5. Have you ever had an injury to your head, face, or jaws? | Y | N |
| 6. Do you suffer from frequent headaches? | Y | N |
| 7. Do you have earaches or neck pains? | Y | N |
| 8. Do you have removable dental appliances? Impants? | Y | N |
| 9. Are you nervous during dental treatment? | Y | N |

10. What is the reason for your dental visit?

11. Date of last dental examination:

12. Date of last dental x-rays:

Please explain any YES answers:

## B. GENERAL INFORMATION

| | | |
|---|---|---|
| 1. When was your last medical checkup? Date: | | |
| 2. Are you being treated for any medical condition or have you been treated within the past year? | Y | N |
| 3. Has there been any change in your general health in the past year? | Y | N |
| 4. Have you ever been hospitalized for any illnesses or operations? | Y | N |
| 5. Do you have a prosthetic or artificial joint (e.g., hip, knee)? | Y | N |
| 6. Have you ever been advised to take antibiotics before dental treatment? | Y | N |
| 7. Have you ever had a peculiar or adverse reaction, including allergies, to any medications or injections? | Y | N |
| 8. Do you have any allergies to any foods or materials (e.g., latex or metals)? | Y | N |
| 9. Do you have any other allergies (e.g., hay fever, animals)? | Y | N |
| 10. Cancer? | Y | N |
| 11. Dry mouth? | Y | N |

**Do you have or have you ever had:**

| | | |
|---|---|---|
| 12. Ear or hearing problems? | Y | N |
| 13. Eye problems (e.g., require corrective lenses, glaucoma)? | Y | N |
| 14. Sleep disorders? | Y | N |

### WOMEN

| | | |
|---|---|---|
| 15. Are you or could you be pregnant? If yes, expected delivery date: | Y | N |
| 16. Are you breastfeeding? | Y | N |
| 17. Are you taking hormone replacement therapy? | Y | N |

Please explain any YES answers:

18. Are you taking medications of any kind? Include prescribed drugs, over-the-counter medications (e.g., cold and flu remedy), and natural health products (e.g., vitamins, herbal, and diet supplements). If yes, please list.

| **Drug Name** | **Amount, Dose, Frequency** (e.g., One 80 mg tablet 3 times per day) | **Reason** | **Date Prescribed and Prescriber** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## C. CARDIO/RESPIRATORY

| Do you have or have you ever had: | | |
|---|---|---|
| 1. Cardiovascular diseases? If yes, specify below: | Y | N |

❑ Angina ❑ Heart attack
❑ Arteriosclerosis ❑ Heart murmur
❑ Artificial heart valves ❑ High or low blood pressure
❑ Congenital heart defects ❑ High or low cholesterol
❑ Congestive heart failure ❑ Mitral valve prolapse
❑ Coronary artery disease ❑ Pacemaker/defibrillator
❑ Damaged heart valves ❑ Rheumatic heart disease/fever

| | | |
|---|---|---|
| 2. Chest pains upon exertion? | Y | N |
| 3. Shortness of breath? | Y | N |
| 4. Asthma? | Y | N |
| 5. Chronic bronchitis or emphysema? | Y | N |
| 6. Sinus trouble or nasal congestion? | Y | N |
| 7. Tuberculosis? | Y | N |
| 8. A persistent cough for more than 3 weeks? | Y | N |
| 9. Cough that produces blood? | Y | N |

Please explain any YES answers:

## D. ENDOCRINE/DIGESTIVE

| Do you have or have you ever had: | | |
|---|---|---|
| 1. Malnutrition? | Y | N |
| 2. Eating disorder? | Y | N |
| 3. Dietary restrictions (self-imposed or doctor prescribed)? | Y | N |
| 4. Night sweats? | Y | N |
| 5. Slow healing or recurrent infections? | Y | N |
| 6. Thyroid or parathyroid disease? | Y | N |
| 7. Diabetes? If yes, indicate type: | Y | N |

Please explain any YES answers:

## E. GASTEROINTESTINAL/GENITOURINARY

| Do you have or have you ever had: | | |
|---|---|---|
| 1. Hepatitis, jaundice, or liver disease? | Y | N |
| 2. Difficulty swallowing? | Y | N |
| 3. G.E. reflux/persistent heartburn? | Y | N |
| 4. A stomach ulcer? | Y | N |
| 5. Gall bladder problems? | Y | N |
| 6. Kidney or bladder trouble? | Y | N |
| 7. Excessive urination? | Y | N |

Please explain any YES answers:

## F. HEMATOLOGIC

| Do you have or have you ever had: | | |
|---|---|---|
| 1. Prolonged or abnormal bleeding with a simple cut or following surgery, extraction, or an accident? | Y | N |
| 2. A blood transfusion? If yes, date: | Y | N |
| 3. A tendency to bruise easily? | Y | N |
| 4. Any blood disorder (e.g., anemia or hemophilia)? | Y | N |

Please explain any YES answers:

## G. IMMUNE SYSTEM/INFECTIOUS DISEASES

| Do you have or have you ever had: | | |
|---|---|---|
| 1. Systemic lupus erythematosus? | Y | N |
| 2. Painful swollen joints or rheumatoid arthritis? | Y | N |
| 3. HIV/AIDS? | Y | N |
| 4. Other diseases or conditions that affect your immune system (e.g., sarcoidosis, Epstein-Barr, radiotherapy, chemotherapy, steroid therapy)? | Y | N |
| 5. Sexually transmitted diseases (e.g., herpes)? | Y | N |

Please explain any YES answers:

## H. NEUROLOGICAL/MUSCULOSKELETAL

| Do you have or have you ever had: | | |
|---|---|---|
| 1. A stroke? | Y | N |
| 2. Convulsions or seizures (e.g., epilepsy)? | Y | N |
| 3. Mental health disorders? | Y | N |
| 4. Arthritis? | Y | N |
| 5. Osteoporosis or osteopenia? | Y | N |
| 6. Chronic pain? | Y | N |

Please explain any YES answers:

## I. OTHER

| | | |
|---|---|---|
| 1. Do you smoke, chew, or snort tobacco products? | Y | N |
| If yes: Frequency (daily, weekly)? | | |
| Number of years use? | | |
| Have you ever tried to quit? | Y | N |
| Are you interested in quitting? | Y | N |
| 2. Do you have a drug or alcohol dependency? | Y | N |
| 3. Other diseases or medical problems that run in your family? | Y | N |
| 4. Other conditions or medical problems not listed? | Y | N |
| 5. Other special needs that will affect your dental care? | Y | N |

Please explain any YES answers:

**To the best of my knowledge, the above information is correct.**

Client/Parent/Guardian Signature: _____ Date: _____

Reviewed By: _____ (RDH) Date: _____