CEDAR POINTE
PROSTHODONTICS

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Board Certified Prosthodontist
DDS, Cert. Pros, FRCD(C)

MEDICAL & DENTAL HISTORY FORM

Patient Name: _____ Date: _____

DOB: MM / DD / YYYY Age: _____ Height: _____ (in / cm) Weight: _____ (lbs / kg)

Home Address: _____ City: _____ Postal Code: _____

E-mail Address: _____ Phone #: _____

Insurance Carrier: _____ ID #: _____ Group #: _____

Emergency Contact:_____ Phone #: _____ Relationship: _____

Health Card #: _____ Dentist: _____ Physician: _____

Physician Address: _____ Pharmacy: _____

STAFF ONLY

☐ Body Mass Index:_____ ☐ BP: _____ ☐ HR: _____ Alerts: _____

CARDIOVASCULAR

1. Have you had / Do you have any of the following cardiovascular problems? ..... ☐ No to all
   - ☐ high blood pressure ☐ heart attack ☐ chest pain ☐ angina
   - ☐ heart valve problem ☐ a pacemaker ☐ rheumatic fever ☐ heart murmur
   - ☐ Other: _____
   - If yes to any, please describe: _____

RESPIRATORY

2. Have you had / Do you have any of the following respiratory problems?..... ☐ No to all
   - ☐ difficulty breathing ☐ current cough ☐ asthma ☐ bronchitis
   - ☐ emphysema ☐ tuberculosis ☐ sleep apnea ☐ CPAP machine
   - ☐ shortness of breath after climbing two flights of stairs / walking two city blocks
   - ☐ Other: _____
   - If yes to any, please describe: _____
3. Do you currently smoke or have you ever smoked?..... ☐ No to all
   - ☐ cigarettes ☐ cigars ☐ vape pen/stick ☐ marijuana
   - If Yes: Cigarettes per day: _____ Packs per day: _____ Number of years of smoking: _____
   - If you stopped smoking: When did you stop? _____ Pack years smoking: _____

GASTROINTESTINAL & ENDOCRINE

4. Have you had / Do you have any of the following conditions?..... ☐ No to all
   - ☐ bleeding conditions ☐ taking blood thinners ☐ jaundice or hepatitis ☐ liver disease
   - ☐ diabetes (type 1 or 2?) ☐ HIV or AIDS ☐ thyroid conditions ☐ kidney problems
   - ☐ stomach problems ☐ intestinal problems ☐ heart burn or acid reflux
   - ☐ Other: _____
   - If yes to any, please describe: _____

FOR FEMALES ONLY

5. For females of child-bearing age:..... ☐ No to all
   - ☐ is there a possibility of pregnancy? ☐ are you currently breastfeeding?

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JOINTS & BONES

6. Have you had / Do you have any of the following? ..... ☐ No to all
   - ☐ taken cortisone, prednisone, or steroids in the last 6 months?
   - ☐ had a joint replacement If yes: Joint(s) replaced: _____ Surgery date: _____
   - ☐ do you require antibiotics before dental procedures? If yes: Which one: _____
   - ☐ taken bone strengthening medications (bisphosphonates) for osteoporosis?
     If yes: Which one: _____ Start date: _____ Stop date: _____

OTHER

7. Have you had / Do you have any of the following? ..... ☐ No to all
   - ☐ major surgery? If yes: For what & when? _____
   - ☐ cancer? If yes: Type:_____ Treatment? _____
   - ☐ a drug addiction or use any recreational drugs? If yes: Which one: _____

MEDICATIONS & ALLERGIES

8. Do you take any medications (including prescriptions, over the counter, and herbals)?..... ☐ No
   If Yes: Indicate (Name & Dose): _____
   _____
9. Do you have any allergies (such as latex, penicillin, codeine, environmental, etc.)? ..... ☐ No
   If Yes: Indicate: _____

DENTAL CONCERNS

10. Do you have any concerns about how your smile looks (*aesthetics*)? ..... ☐ Yes ☐ No
    If Yes: Indicate: _____
11. Do you have any difficulties with eating or chewing (*function*) or talking (*speech*)? ..... ☐ Yes ☐ No
    If Yes: Indicate: _____
12. Have you had any problems associated with past dental treatment? ..... ☐ Yes ☐ No
    If Yes: Indicate: _____
13. Are you under the regular care of a dentist and/or hygienist?..... ☐ Yes ☐ No

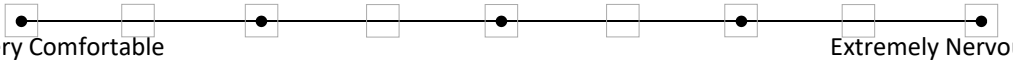
DENTAL PROBLEMS

14. Do you have any of the following dental problems?..... ☐ No to all
    - ☐ tooth or gum pain ☐ bleeding gums ☐ sensitive teeth ☐ loose or mobile teeth
    - ☐ bad breath ☐ bad taste in mouth ☐ discoloured teeth ☐ sores / bumps / swellings
    - ☐ missing tooth/teeth ☐ jaw joint click/pain ☐ limited mouth opening ☐ grinding / clenching habit
    - ☐ Other: _____

    If yes to any, please describe: _____
15. Any other dental concerns/problems that are not listed? _____

DENTAL ANXIETY

16. Would you be interested in discussing sedation options (laughing gas, oral sedation, GA)? ..... ☐ Yes ☐ No
17. Please circle the black dot on the scale below to indicate your comfort level with dentistry:



Very Comfortable Extremely Nervous

_____ _____

Signature: ☐ Patient ☐ Parent ☐ Guardian Witness (Dentist or Hygienist)

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