HEALTH HISTORY

Name: Mr/Mrs/Miss/Ms/Dr. : _____
Address: _____City:_____ Postal Code: _____
Home #:_____Cell#:_____Business#:_____Email:_____
D.O.B.:_____ Who Referred you to our Office: _____
Name of Family Doctor: _____ Phone #:_____

In Case of Emergency, We should notify:
Name: _____ Relationship: _____ Phone #: _____

Dental History:

What is the reason for today's visit? _____
When was your last dental visit? _____
Are your teeth sensitive to: __Cold __Sweet__ Heat __Other _____
Do your jaws crack or pop when you open widely? Yes/No_____
Do you grind or clench your teeth? Yes/ No_____

Medical History:

Are you currently receiving care? Yes/No If yes, nature of care: _____
Have you ever been hospitalized? Yes/No Explain:_____

Please list any medications you are currently taking and dosages, including any dietary or herbal supplements, and for what purpose.

1._____ Reason:_____
2._____ Reason:_____
3._____ Reason:_____
4._____ Reason:_____

Have you ever taken prolonged medical or non-medical drugs? Yes/No Which? _____

Are you taking any of these medications?

Pre-medication before dental treatment?	**No**	**Yes**	**Tagamet® (cimetidine) or Prilosec® (omeprazole)?**	**No**	**Yes**
Antacids?	**No**	**Yes**	**Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?**	**No**	**Yes**
St. John's Wort or Kava-Kava?	**No**	**Yes**	**Serzone® (nefazodone)**	**No**	**Yes**
Dilantin® or Tegretol®	**No**	**Yes**	**Diflucan® (fluconazole) or Sporonox® (itraconazole)**	**No**	**Yes**
Barbiturates (any)	**No**	**Yes**	**Biaxin® (clarithromycin)**	**No**	**Yes**
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, Reclast) or Prolia? If so, when did the treatment begin? When did the treatment end?				**No**	**Yes**
Have you ever taken any prescription drugs such as fen-phen for weight loss?				**No**	**Yes**
Do you consume grapefruit juice, grapefruits or grapefruit extract?				**No**	**Yes**

Are you allergic or have you had a reaction to:

Local anesthetics or epinephrine……...Yes/No
Penicillin or other antibiotics……Yes/No
Aspirin, Ibuprofen or Tylenol…….....Yes/No
Latex or Metals…… Yes/No
Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives ……. Yes/No

Women:

Are you pregnant?.....Yes/No
Are you a nursing mother?..... Yes/No
If no, are you planning a pregnancy in the near future?..... Yes/No
Are you taking birth control pills?..... Yes/No

HEALTH HISTORY

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Disorders?	**No**	**Yes**	**Hepatitis, Any Form**	**No**	**Yes**
Arthritis, Rheumatism or other inflammatory disease?	**No**	**Yes**	**Joint Replacement? When placed?**	**No**	**Yes**
Asthma, COPD or other Lung Diseases	**No**	**Yes**	**Kidney Disease**	**No**	**Yes**
Abnormal Bleeding from a cut?	**No**	**Yes**	**Liver Disease (including Jaundice)**	**No**	**Yes**
Cancer or Tumor?	**No**	**Yes**	**Sore/Enlarged Lymph Nodes**	**No**	**Yes**
Diabetes	**No**	**Yes**	**Psychiatric Therapy**	**No**	**Yes**
Emphysema or other Respiratory/Lung Illnesses	**No**	**Yes**	**Previous Biopsies**	**No**	**Yes**
Epilepsy	**No**	**Yes**	**Radiation or Chemotherapy Treatment**	**No**	**Yes**
Fainting or Dizzy Spells	**No**	**Yes**	**Renal Dialysis**	**No**	**Yes**
Glaucoma	**No**	**Yes**	**Slow-Healing Mouth Sores**	**No**	**Yes**
Previous Bacterial Endocarditis	**No**	**Yes**	**Unintentional Weight Loss/Gain**	**No**	**Yes**
Heart Valve (artificial) or Heart Transplant	**No**	**Yes**	**H.I.V. Infection/AIDS or ARC**	**No**	**Yes**
Congenital Heart Disease	**No**	**Yes**	**Venereal Disease**	**No**	**Yes**
Heart Disease, Heart Attack, Heart Surgery, Angina	**No**	**Yes**	**Do you Smoke? How Much?_____**	**No**	**Yes**
Heart Stent? When placed?	**No**	**Yes**	**Recurrent Illnesses**	**No**	**Yes**

Abnormal Blood Pressure?..... Yes/No **"high blood pressure" or "low blood pressure"?**

_____ _____ _____

Patient (Print Name) ***Patient Signature*** ***Date***

Anti Spam Consent

Dr. Younes Dental Care has the ability to communicate with our patients via text and/or emails, of upcoming appointments or any futures events or news happening at Dr. Younes Dental Care. While we do not consider these communications to be "spam", they are nonetheless considered to be electronic messages "by Canada's new anti-spam law.

Please note you can unsubscribe from messages we send anytime by simply clicking "unsubscribe" at the bottom of The bottom of the emails, or the Word STOP on any text message you receive.

By Signing you give Dr. Younes Dental Care and staff consent to communicate with you via email and/or text.

Patients Signature:_____ Date:_____

Insurance (patients with insurance)

I hereby authorize the release of information contained in the claims to be submitted electronically to my Insuring company and I authorize direct payment to Dr. Younes Dental Care for the benefits from claims Submitted electronically.

Patients Signature:_____ Date:_____

HEALTH HISTORY

Please complete if you are presently interested or may be interested in sedation

Name:_____

Age:_____ Height:_____ Blood Pressure:_____/_____

Date of last health care exam:_____ What was the exam for:_____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. **_____**
2. **_____**
3. **_____**

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): ***none slight moderate high***			

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? long?	**No**	**Yes**
Do you want to quit using tobacco?	**No**	**Yes**
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	**No**	**Yes**
Do you use any mood altering drugs other than those previously listed?	**No**	**Yes**

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient Signature:_____ Date:_____