Kootenay River Dental Hygiene Inc.
Andrea Noel, RRDH, B.Sc (DH)

Medical History

Do you have a personal physician? Yes No

Physician's Name:_____

Address:_____

Phone #:_____Date of last visit:_____

Your current physical health is: good fair poor

Are you currently under the care of a physician? Y N
Please explain:_____

Do you smoke or use tobacco in any form? Y N
Have you had any metal rods, pins or implants? Y N
Are you taking any medications? Y N
Please list each:_____
_____
_____

Have you had any of the following diseases or medical problems

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joint/ Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Colitis
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Seizures
Y N Epilepsy
Y N Fainting Spells
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Herpes/ cold sores
Y N HighBloodPressure
Y N Hospitalization
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral ValveProlapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Shingles
Y N Sickle Cell Disease
Y N Frequent Headaches
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions that you have had:
_____

Are you allergic to any of the following?

Y N Aspirin
Y N Penicillin
Y N Jewelry/Metals
Y N Dental Anesthetics
Y N Other
Y N Erythromycin
Y N Codeine
Y N Tetracycline
Y N Latex

Please list any other drug/materials that you are allergic to:_____
_____

Dental History

Are you currently in pain? Yes No

Have you ever taken Fosamax (Alendronate for osteoporosis) ? Yes No
If so, when: _____

Do you require Antibiotics before dental treatment? Yes No

Have you ever had a serious/difficult problem any problems with any dental work? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain discomfort in your jaw joint (TMJ/TMD)? Yes No

Any unfavorable dental hygiene experience?Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

How many times do you:floss/week__brush/day___

Are your teeth sensitive to heat, cold or anything else?

Have you lost any teeth? Yes No If so why?
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information is legislated under the Freedom of Information and Protection of Privacy Act and it is my responsibility to inform Kootenay River Dental Hygiene Inc. of any changes in my medical status.

_____
Signature Date