



DR. ANDREA DERNISKY  
& ASSOCIATES

## SUTER BROOK DENTAL GROUP

### Medical & Dental History

First and Last Name: \_\_\_\_\_

Date of Birth: Y \_\_\_/M \_\_\_/D \_\_\_     Male  Female    Phone #: Home \_\_\_\_\_ Cell \_\_\_\_\_

Home Address: \_\_\_\_\_

City/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**How did you hear of us?**     123 Website     Live in Village     Patient Referral     Google     Radio     Other

#### MEDICAL HISTORY QUESTIONNAIRE

Have you ever had minimal or moderate sedation?     Yes  No    If yes, When? \_\_\_\_\_

Any complications?     Yes  No    If yes, please explain \_\_\_\_\_

Any history of family sedation/anesthetic complications?     Yes  No    If yes, please explain \_\_\_\_\_

Are you presently being treated for any medical condition or have you been in the past 2 years?     Yes  No

If yes, please explain \_\_\_\_\_

When was your last visit to a physician? \_\_\_\_\_ Last complete medical examination? \_\_\_\_\_

Have you been hospitalized in the last five years?     Yes  No

If yes, please explain \_\_\_\_\_

**Are you taking any prescription or non-prescription drugs?**     Yes  No

If yes, please specify drug(s), dosage(s) and for how long? \_\_\_\_\_

**Have you ever had a reaction to any drug(s) or been advised against taking any kind of medication?**     Yes  No

If yes, please explain (e.g., penicillin, sulpha, codeine) \_\_\_\_\_

Do you have any sensitivities or allergies?     Yes  No    If yes, please explain \_\_\_\_\_

Do you have any history of family disease?     Yes  No    If yes, please explain \_\_\_\_\_

Do you smoke or use other forms of tobacco?     Yes  No    If yes, number/day and for how many years \_\_\_\_\_

Do you have a history of alcohol and/or drug abuse?     Yes  No

Have you received treatment for alcohol or drug use?     Yes  No

Do you currently have, or have you had in the past, any disease, condition or problem not listed?     Yes  No

If yes, please explain \_\_\_\_\_

Is there any problem or medical condition that you wish to discuss in private with the dentist?     Yes  No

**WOMEN ONLY:** Are you pregnant or suspect you might be?  Yes  No Anticipated delivery date? \_\_\_\_\_

Are you breast feeding?  Yes  No

Are you taking birth control pills?  Yes  No

**Indicate which of the following you presently have or have ever had:**

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/steroid therapy
<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Earaches (frequent)
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Changes in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizzy spells
<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	Glandular disorders
<input type="checkbox"/>	<input type="checkbox"/>	Bleed easily	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment
<input type="checkbox"/>	<input type="checkbox"/>	Headaches (severe)	<input type="checkbox"/>	<input type="checkbox"/>	Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	Radiation or chemotherapy treatment
<input type="checkbox"/>	<input type="checkbox"/>	Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Malignant hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	Temperature intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Medical implant	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain/loss
<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's disease	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary edema			
<input type="checkbox"/>	<input type="checkbox"/>	Hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive			

**NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE**

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted, if necessary, to obtain information that is required for my dental care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by dentist: \_\_\_\_\_ Date: \_\_\_\_\_