ZURICH DENTAL

21 Main St., Zurich, ON N0M 2T0
Phone: (519) 236-4341
Fax: (519) 236-7758
dentaloffice@hay.net
www.zurichdental.ca

Medical History Form

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

Preferred Name: _____

Do you have a family doctor? ◯ YES ◯ NO Name: _____

Are you hard of hearing? ◯ YES ◯ NO Do you wear hearing aids? ◯ YES ◯ NO

Do you wear glasses? ◯ YES ◯ NO Do you wear contact lenses? ◯ YES ◯ NO

Do you smoke? ◯ YES ◯ NO How often? _____

Do you use recreational drugs? ◯ YES ◯ NO How often? _____

Do you consume alcohol? ◯ YES ◯ NO How often? _____

WOMEN ONLY

Are you pregnant? ◯ YES ◯ NO If yes, what month are you in? _____

Do you take birth control pills? ◯ YES ◯ NO

Which pharmacy do you use? _____

Do you take any prescription medication? ◯ YES ◯ NO

Please list medication and dose: _____

Do you take any non-perscription medication and/or supplement? ◯ YES ◯ NO

Please list any supplements or non-prescription medication and dose: _____

Do you have any allergies to:

Medications: ◯ YES ◯ NO If so, what type: _____

Latex/Rubber Products? ◯ YES ◯ NO

Others (Food/Seasonal)? ◯ YES ◯ NO If so, what type: _____

Have you ever been told you need to take medication before coming to the dentist? ◯ YES ◯ NO

If so, what type? _____

Have you ever had any injury, surgery, or radiation to your face or jaw? ◯ YES ◯ NO

Have you had your wisdom teeth removed? ◯ YES ◯ NO

Do you have frequent headaches, TMJ, grinding, or clenching? ◯ YES ◯ NO

Do you wear a night guard or retainer? ◯ YES ◯ NO

Are you taking blood thinners? ◯ YES ◯ NO

Are you taking bone strengthening medication? ◯ YES ◯ NO

Is there something about your smile that you would like to improve? _____

Do you have any concerns with your teeth that you would like us to know about? _____

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Check all that apply

- ☐ Heart murmur or mitral valve prolapse
- ☐ Stomach or intestinal problems
- ☐ Joint replacement (hip, knee, etc)
- ☐ Mental health concern
- ☐ High or low blood pressure
- ☐ Hyper or hypo glycemia
- ☐ Epilepsy or seizures
- ☐ Malignant hyperthermia
- ☐ Drug or alcohol addiction
- ☐ Venereal disease
- ☐ Any lung disease
- ☐ Thyroid disease
- ☐ Arthritis or rheumatism
- ☐ Scarlett or rheumatic fever
- ☐ AIDS
- ☐ Positive testing for HIV virus
- ☐ Jaundice
- ☐ Diabetes, If so what type: _____
- ☐ Tuberculosis
- ☐ Stroke - Date: _____
- ☐ Hepatitis A/B/C
- ☐ Herpes/Cold Sores
- ☐ Heart Attack - Date: _____
- ☐ High Cholesterol
- ☐ Active Cancer - Date: _____
  Chemotherapy? ◯YES ◯NO Radiation? ◯YES ◯NO
- ☐ Previous Cancer: Type: _____
  In remission since: _____
- ☐ Kidney disease
- ☐ Sinus trouble
- ☐ Liver disease
- ☐ Cortisone/steroid therapy
- ☐ Asthma
- ☐ Dizziness
- ☐ Excessive bleeding/bruise easily
- ☐ Nervous/Anxiety
- ☐ Other: _____

Is there anything else you would like us to be aware of? _____

Surgeries: ◯ YES ◯ NO

Previous Surgery: _____ Date: _____

Previous Surgery: _____ Date: _____

Previous Surgery: _____ Date: _____

Informed Consent

I, the undersigned, have provided a complete and accurate Medical/Dental History. To the best of my knowledge, the above information is correct. I authorize the dentist to contact my physician and/or pharmacist if necessary. I authorize the dentist to perform diagnostic, dental, and oral surgery procedures and services, including the use of anaesthetic as necessary. I also understand and assume any and all fees associated with these procedures and services provided to me or my dependents. If I ever have any change in my health or medications, I will inform the dental team at Zurich Dental at the next appointment without fail. I authorize Zurich Dental to use photographs and xrays of my jaw and teeth that are valuable for educational purposes. These images may be used for dental education including lectures, seminars, demonstrations, professional publications, marketing material including social media platforms and printed materials. I understand my identity and any identifiable information will be kept concealed and confidential for these purposes.

Patient Signature: _____ Date: _____

If patient is under 18 years of age, parent or legal guardian must sign.