Dr. Gayle Wagman
Dr. Michelle Crystal

416-651-2422
2568 EGLINTON AVENUE WEST,
TORONTO, ONTARIO M6M 1T4

MEDICAL AND DENTAL QUESTIONNAIRE FOR ADULTS

Mark your response to indicate if you have had any of the following diseases or problems.
Mark don't know **(DK)** if you are unsure whether you have had the disease or problem. If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

PATIENT INFORMATION

TODAY'S DATE:

PATIENT NAME:

ADDRESS:

PREFERRED CONTACT #

EMAIL:

DATE OF BIRTH:

EMERGENCY CONTACT:

EMERGENCY CONTACT PHONE:

HOW DID YOU HEAR ABOUT OUR OFFICE

DO YOU HAVE DENTAL INSURANCE? WHO IS THE PROVIDER?

DENTAL INFORMATION

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? ☐ YES ☐ NO

ARE YOU SATISFIED WITH THE FUNCTION OF YOUR TEETH? ☐ YES ☐ NO

DOES FOOD FREQUENTLY GET CAUGHT BETWEEN TEETH? ☐ YES ☐ NO

DO YOUR GUMS OFTEN BLEED WHILE BRUSHING? ☐ YES ☐ NO

HAVE YOU NOTICED LOOSENING OF YOUR TEETH? ☐ YES ☐ NO

HAVE YOU INJURED YOUR HEAD, NECK, OR JAW? ☐ YES ☐ NO

DO YOU HAVE DIFFICULTY EATING OR SWALLOWING? ☐ YES ☐ NO

DO YOU HAVE A DRY MOUTH? ☐ YES ☐ NO

PROBLEMS OF THE JAW – HAVE YOU NOTICED

CLICKING OF THE JAW? ☐ YES ☐ NO

DIFFICULTY OPENING OR CLOSING? ☐ YES ☐ NO

DIFFICULTY CHEWING? ☐ YES ☐ NO

ORAL HABITS - DO YOU

CLENCH OR GRIND YOUR TEETH? ☐ YES ☐ NO

BITE YOUR LIPS OR CHEEK FREQUENTLY? ☐ YES ☐ NO

HAVE YOU HAD

ORTHODONTIC TREATMENT (BRACES)? ☐ YES ☐ NO

ORAL SURGERY? ☐ YES ☐ NO

GUM TREATMENT? ☐ YES ☐ NO

A BITE PLANE, NIGHTGUARD OR SNORING APPLIANCE? ☐ YES ☐ NO

DO YOU CURRENTLY HAVE

DENTAL PAIN? ☐ YES ☐ NO

SORES OR SWELLINGS IN YOUR MOUTH? ☐ YES ☐ NO

A PARTIAL/FULL DENTURE OR DENTAL IMPLANTS? ☐ YES ☐ NO

HAVE YOU HAD ANY DIFFICULTY WITH DENTAL TREATMENT? ☐ YES ☐ NO

DATE OF LAST DENTAL X-RAYS

HOW OFTEN DO YOU BRUSH YOUR TEETH?

HOW OFTEN DO YOU FLOSS?

DATE OF LAST DENTAL TREATMENT

DATE OF LAST TEETH CLEANING

REASON FOR TODAY'S DENTAL VISIT?

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MEDICAL INFORMATION

PHYSICIAN INFORMATION

NAME

PHYSICIAN PHONE

PHYSICAL EXAMINATION LAST DATE

ANY CHANGES IN YOUR HEALTH WITHIN THE PAST YEAR?

CARDIOVASCULAR

HIGH BLOOD PRESSURE	☐ YES	☐ NO	☐ DK
ANGINA (CHEST PAIN)	☐ YES	☐ NO	☐ DK
HEART ATTACK	☐ YES	☐ NO	☐ DK
IRREGULAR HEART BEAT	☐ YES	☐ NO	☐ DK
HEART SURGERY	☐ YES	☐ NO	☐ DK
HEART FAILURE	☐ YES	☐ NO	☐ DK
DAMAGED HEART VALVE	☐ YES	☐ NO	☐ DK
HIGH CHOLESTEROL	☐ YES	☐ NO	☐ DK
STROKE	☐ YES	☐ NO	☐ DK

HEMATOLOGIC

ANEMIA	☐ YES	☐ NO	☐ DK
SICKLE CELL ANEMIA	☐ YES	☐ NO	☐ DK
ABNORMAL BLEEDING	☐ YES	☐ NO	☐ DK

RESPIRATORY

ASTHMA	☐ YES	☐ NO	☐ DK
EMPHYSEMA/ BRONCHITIS/ COPD	☐ YES	☐ NO	☐ DK
SLEEP APNEA	☐ YES	☐ NO	☐ DK
DIFFICULTY BREATHING	☐ YES	☐ NO	☐ DK
TUBERCULOSIS	☐ YES	☐ NO	☐ DK

ENDOCRINE

DIABETES	☐ YES	☐ NO	☐ DK
THYROID PROBLEM	☐ YES	☐ NO	☐ DK

RENAL

KIDNEY DISORDER	☐ YES	☐ NO	☐ DK
DIALYSIS	☐ YES	☐ NO	☐ DK

IMMUNE

PAST USE OF STEROIDS	☐ YES	☐ NO	☐ DK
DELAYED HEALING	☐ YES	☐ NO	☐ DK

MUSCULOSKELETAL

ARTHRITIS	☐ YES	☐ NO	☐ DK
ARTIFICIAL JOINT	☐ YES	☐ NO	☐ DK
FIBROMYALGIA	☐ YES	☐ NO	☐ DK
LUPUS	☐ YES	☐ NO	☐ DK

GASTROINTESTINAL

ACID REFLUX/GERD	☐ YES	☐ NO	☐ DK
IRRITABLE BOWEL SYNDROME	☐ YES	☐ NO	☐ DK
STOMACH ULCER	☐ YES	☐ NO	☐ DK

HEPATIC

LIVER DISEASE	☐ YES	☐ NO	☐ DK
JAUNDICE	☐ YES	☐ NO	☐ DK
HEPATITIS	☐ YES	☐ NO	☐ DK

NEUROLOGIC

EPILEPSY/SEIZURES	☐ YES	☐ NO	☐ DK
PARKINSON'S DISEASE	☐ YES	☐ NO	☐ DK
MULTIPLE SCLEROSIS	☐ YES	☐ NO	☐ DK
HEADACHES	☐ YES	☐ NO	☐ DK

SKIN

HIVES OR SKIN RASH	☐ YES	☐ NO	☐ DK
OTHER SKIN LESIONS	☐ YES	☐ NO	☐ DK

EYES/EARS

GLAUCOMA	☐ YES	☐ NO	☐ DK
IMPAIRED VISION/HEARING	☐ YES	☐ NO	☐ DK

MENTAL HEALTH

PSYCHIATRIC DISORDERS	☐ YES	☐ NO	☐ DK
DEPRESSION	☐ YES	☐ NO	☐ DK
ANXIETY	☐ YES	☐ NO	☐ DK
EATING DISORDERS	☐ YES	☐ NO	☐ DK
SLEEP DISORDER	☐ YES	☐ NO	☐ DK
DEMENTIA	☐ YES	☐ NO	☐ DK

INFECTIONS

HIV POSITIVE/AIDS	☐ YES	☐ NO	☐ DK
SEXUALLY TRANSMITTED DISEASE	☐ YES	☐ NO	☐ DK

ALLERGIES

LOCAL ANESTHETIC	☐ YES	☐ NO	☐ DK
ANTIBIOTICS	☐ YES	☐ NO	☐ DK
ASPIRIN/ADVIL	☐ YES	☐ NO	☐ DK
ACETAMINOPHEN (TYLENOL)	☐ YES	☐ NO	☐ DK
CODEINE/NARCOTICS	☐ YES	☐ NO	☐ DK
METALS	☐ YES	☐ NO	☐ DK
LATEX	☐ YES	☐ NO	☐ DK
OTHER	☐ YES	☐ NO	☐ DK

OTHER

ARE YOU PREGNANT?	☐ YES	☐ NO	☐ DK
NURSING INFANT	☐ YES	☐ NO	☐ DK
CANCER	☐ YES	☐ NO	☐ DK
CANCER TREATMENT	☐ YES	☐ NO	☐ DK

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SUBSTANCE USE

TOBACCO USE? ☐ YES ☐ NO ☐ DK

HOW MANY CIGARETTES A DAY? ☐ YES ☐ NO ☐ DK

RECREATIONAL DRUG USE ☐ YES ☐ NO ☐ DK

ALCOHOL USE? ☐ YES ☐ NO ☐ DK

HOW MY DRINKS A WEEK? ☐ YES ☐ NO ☐ DK

CHEMICAL DEPENDENCY ☐ YES ☐ NO ☐ DK

PLEASE LIST ANY DISEASE, CONDITION, OR PROBLEM YOU HAVE THAT IS NOT LISTED ABOVE.

PLEASE LIST ANY HOSPITALIZATIONS OR SURGERIES YOU HAVE HAD.

PLEASE EXPLAIN IF YOU ANSWERED "YES" TO, OR ARE UNCERTAIN ABOUT, ANY OF THE ABOVE ITEMS ☐ YES ☐ NO

IS THERE ANYTHING PARTICULAR YOU WOULD LIKE US TO KNOW ABOUT YOURSELF? HOW DO YOU FEEL ABOUT DENTAL CARE?

MEDICATION LIST

PLEASE INCLUDE ALL DRUGS, MEDICATIONS, VITAMINS AND SUPPLEMENTS.

NAME OF PHARMACY

NUMBER OF THE PHARMACY

1- MEDICATION & DOSE

1- CONDITION PRESCRIBED FOR

1- DATE STARTED

2- MEDICATION & DOSE

2- CONDITION PRESCRIBED FOR

2- DATE STARTED

3- MEDICATION & DOSE

3- CONDITION PRESCRIBED FOR

3- DATE STARTED

PATIENT CONSENT

I, THE UNDERSIGNED, CERTIFY THAT ALL OF THE ABOVE MEDICAL AND DENTAL INFORMATION IS TRUE TO MY KNOWLEDGE AND I HAVE NOT OMITTED ANY PERTINENT INFORMATION. I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OF ADVISABLE, INCLUDING THE USE OF LOCAL ANAESTHETIC AS INDICATED, AND I WIL ASSUME RESPONSIBILITY FOR FEES ASSOCIATES WITH THESE PROCEDURES.

PATIENT(PARENT, GUARDIAN)

SIGNATURE

DATE