Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Department of Dentistry:
Confidential Patient Health Questionnaire

PLEASE PRINT

Today's Date _____ _____ _____
YYYY MM DD

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Middle Name: _____ Male ☐ Female ☐ D.O.B _____ _____ _____
YYYY MM DD

Address: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: ( ) _____ Business: ( ) _____ Other: ( ) _____

Email: _____

Emergency Contact _____ Phone: ( ) _____ Other: ( ) _____

Ontario Health Insurance Card #: _____ Version Code: _____

Dental Insurance: Yes ☐ No ☐ ODSP ☐ Ontario Works (OW) ☐

☐ Other: _____

PHYSICIAN INFORMATION

Family Physician: _____ Phone: ( ) _____

Address: _____ Last Visit: _____

Family Dentist: _____ Phone: ( ) _____

Address: _____ Last Visit: _____

Other Doctors/Specialists: _____

_____

Who referred you to our Clinic?

_____ For what reason? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS – THIS IS IMPORTANT FOR YOUR CARE

1. Are you currently under the care of a medical doctor or specialist? Yes ☐ No ☐ Why? _____

2. Have you ever had any type of operation? YES ☐ NO ☐ If yes, please explain: _____

3. Have you ever had any serious Illnesses? YES ☐ NO ☐ If Yes, please explain _____

4. Has there been any change to your general health in the last year? YES ☐ NO ☐
   If yes, please explain _____

5. Are you taking any drugs, pills, medicine or over the counter (non-prescription) medications including vitamins and herbal supplements? **PLEASE LIST, or attach a list of your medications.**
   a) _____ b) _____ c) _____
   d) _____ e) _____ f) _____

6. Tell us about other medication(s) you have taken in the past. _____

7. Do you have any allergies to:
   a) Medications? YES ☐ NO ☐ Please List _____

   b) Latex rubber products/other materials? YES ☐ NO ☐
   c) Food? YES ☐ NO ☐ Please List _____ _____

   d) Environment? YES ☐ NO ☐ Please List _____

   What was the reaction? _____

8. Have you ever had a bad reaction to local anesthetic or general anesthetic? YES ☐ NO ☐
   If yes, please describe: _____

9. Do you now use, or have use used within the past five years, **ANY** Recreational or Street Drugs or Substances? YES ☐ NO ☐ If yes, which ones? _____
   _____ How Often?

10. Do you drink beer, wine, liquor or other alcoholic beverages? YES ☐ NO ☐
    How often? _____ How Much? _____

11. Have you had radiation, chemotherapy, or other treatments for cancer, tumor, bowel problems, joint, or skin problem disorders? YES ☐ NO ☐ Please describe: _____

12. Have you ever been admitted to a hospital? YES ☐ NO ☐ If yes, why? _____

13. Have you ever been told you have MRSA? YES ☐ NO ☐ When? _____
    Are you MRSA Positive ☐ Negative ☐

14. Have you ever been told you have VRE? YES ☐ NO ☐ When? _____
    Are you MRSA Positive ☐ Negative ☐

CHECK THE PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST

CENTRAL NERVOUS SYSTEM:

( ) Head Injury
( ) Sleep Problems (e.g. Sleep Apnea)
( ) Migraine
( ) Psychiatric Disorder
( ) Malignant Hyperthermia
( ) Multiple Sclerosis (MS)
( ) Alzheimer's Disease/Dementia
( ) Other: _____
( ) Sight or Hearing Disorder
( ) Nervous Disorder
( ) Autism / ADD / ADHD
( ) Parkinson's disease
( ) Fainting Spells
( ) Facial Pain Disorders
( ) Cognitive Impairment (e.g. Memory/Concentration)
( ) Recurring Headaches
( ) Cerebral Palsy
( ) Seizures or Convulsions
( ) Developmental Delay
( ) Epilepsy
( ) Stroke

CARDIOVASCULAR SYSTEM:

( ) Heart Attack
( ) Congenital Heat Disease
( ) Congestive Failure
( ) Heart Surgery
( ) Anemia (Low Blood Count)
( ) Shortness of Breath
( ) Heart Murmur or Mitral Valve Prolapse
( ) Bleeding or Clotting Disorder
( ) Heart or Blood Pressure Problems
( ) Irregular Pulse or Heart Beat
( ) Easy Bruising
( ) Angina/Chest Pains
( ) Rheumatic Fever
( ) Do you have a Pacemaker
( ) High or Low Blood Pressure
( ) Prolonged Bleeding (e.g. after cut or dental extraction)
( ) Have you had a Blood or Blood — Product Transfusion
( ) Blood clots in the leg or other blood vessels (deep vein thrombosis)
( ) Limits to walking/work/exercise/sports
( ) Artificial/Prosthetic Heart Valve or Artery/Vein

RESPIRATORY SYSTEM:

( ) Hay Fever
( ) Shortness of Breath
( ) Tuberculosis (TB)
( ) Lung Disorder
( ) Sleep Apnea
( ) Emphysema
( ) Asthma
( ) Collapsed Lung
( ) pulmonary embolus/blood clot
( ) Pneumonia
( ) Nasal or Sinus Problems

Do you Smoke? YES ☐ NO ☐ If yes, what/how much/for how long _____

GASTROINTESTINAL SYSTEM:

( ) Recurring Mouth Ulcers
( ) Stomach/Intestinal Ulcers
( ) Liver Disease
( ) Upset stomach or Diarrhea when taking medications
( ) Hepatitis/Jaundice
( ) Cannot take Aspirin
( ) Chronic Constipation
( ) Swallowing Problem
( ) Hiatus Hernia
( ) Intestinal or Bowel Disorders
( ) Irritable Bowel Syndrome

IMMUNE SYSTEM CONCERNS:

( ) Crohn's Disease — Which medications are you taking? _____
( ) Rheumatoid or other types of Arthritis — Which medications are you taking? _____
_____
( ) Multiple Myeloma/Breast Cancer/other cancers — Which medications are you taking? _____
_____
( ) HIV/AIDS — Which medications are you taking? _____
_____

GENITO-URINARY SYSTEM:

( ) Kidney Problems ( ) Bladder Problems ( ) Prostate Problems
( ) Renal Failure ( ) Dialysis Peritoneal/Hemodyalisis ( ) Urinary Tract Problems
( ) Other: _____

ENDOCRINE SYSTEM:

( ) Diabetes: Type I ☐ Type II ☐ ( ) Hormone Problems ( ) Thyroid Problems
( ) HRT ( ) Pituitary Problems ( ) Other

MUSCULOSKELETAL SYSTEM:

( ) Jaw Joint Problems ( ) Physical Impairment/Disability ( ) Dental Implants
( ) Osteoporosis ( ) Arthritis or Joint Problems ( ) Artificial/Prosthetic Joint
( ) Quadriplegia/Paraplegia ( ) Other muscle Problems

Are you taking a specific type of medications called bisphosphonates? YES ☐ NO ☐ Don't know ☐
Are you taking any medications to increase bone density? YES ☐ NO ☐

SKIN:

( ) Skin Lesions/Disorders ( ) Allergy/Hives/Rashes

WOMEN:

Are you Pregnant? _____ Are you Breast Feeding? _____

FAMILY HISTORY:

Is there any one in your family who has or has had any of the following: If yes, please check (✓)
( ) Heart or Blood Pressure Problems ( ) Bleeding disorder ( ) Diabetes
( ) Any reaction to or problems with General Anesthesia (e.g. Malignant Hyperthermia)

Height _____ Weight _____ Lbs ☐ or Kg ☐

Do you have or have you any other medical problem or condition or illness that has not been asked?
If yes, please describe: _____

I acknowledge that I have completed the medical history to the best of my knowledge. I consent to contact with my dentist, physician, or other health care provider regarding clarification of my medical history and to the sharing/ reporting of medical information and my treatment at Mount Sinai Hospital.

PATIENT OR GUARDIAN NAME

(Please print): _____ Signature: _____

OFFICE USE ONLY

History Reviewed: _____ _____ _____
Date Reviewed By–Print Name Signature

History Reviewed: _____ _____ _____
Date Reviewed By–Print Name Signature

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