KILDARE
DENTAL CENTRE

6 - 630 Kildare Avenue East
Winnipeg, MB R2C 0P8
204.222.7252 info@kildaredental.ca

Medical History

Patient Name _____ Date _____

Family Doctor _____ Date of Last Visit _____

Clinic Name & Address _____

Are you currently being tested or treated for any of the following medical conditions? *(check all that apply)*

- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Pacemaker
- ☐ Prosthetic Joints
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Shortness of Breath
- ☐ Stomach Problems

Are you currently being tested or treated for any medical conditions not listed above?

_____

_____

Are you allergic to any medications? _____

Do you have any other allergies? _____

Are you pregnant? ○ Yes ○ No If yes, what is your due date? _____

Are you currently taking any pills or medications? If yes, please list all medications, pills and supplements that you are taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Comments/Notes *(For office use only)*

_____

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Dental History

Who was your previous dentist? _____ Date of Last Visit _____

How would you rate your current dental health? ○ Excellent ○ Good ○ Fair ○ Poor ○ Unsure

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Please answer the following questions:			**Please explain:**
1. Are you currently in any pain or discomfort?	○ Yes	○ No	
2. Do your gums bleed while brushing, flossing or eating?	○ Yes	○ No	
3. Do you have any pain when you chew?	○ Yes	○ No	
4. Have you experienced any pain in muscles of your face?	○ Yes	○ No	
5. Do you have frequent head, neck or shoulder aches?	○ Yes	○ No	
6. Does your jaw crack or pop?	○ Yes	○ No	
7. Does your jaw lock when open or closed?	○ Yes	○ No	
8. Do you chew primarily on one side of your mouth?	○ Yes	○ No	
9. Does food catch between your teeth?	○ Yes	○ No	
10. Do you have trouble breathing through your nose?	○ Yes	○ No	
11. Are you happy with the appearance of your teeth?	○ Yes	○ No	
12. Do you have sensitive teeth?	○ Yes	○ No	

☐ Hot ☐ Cold ☐ Sweet ☐ Pressure

Do any of the following apply to you?

☐ Painful gums ☐ Tooth ache/pain ☐ Loose teeth ☐ Broken teeth
☐ Swollen gums ☐ Mouth sores ☐ Mouth growths ☐ Bad breath

Comments/Notes *(For office use only)*

MEDICAL AND DENTAL HISTORY CONSENT

I, the undersigned, certify that I have provided, to the best of my knowledge, an accurate and complete medical and dental history. I consent to my dentist obtaining from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. I hereby promise to inform my dentist of any changes to my health status. I understand that my medical and dental records may need to be released to another dentist or health care professional if my dental treatment requires it. Medical and dental records will be kept in strict confidence in accordance with PIPEDA and the laws governing the Province of Manitoba.

Name of Patient _____ Signature of Patient/Guardian _____