The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please advise Dr. Navaneelan and her team if there have been any changes in your health history since your last visit. Thank you.

DR. RACHEL NAVANEELAN & ASSOCIATES FAMILY AND COSMETIC DENTISTRY
MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **BIRTHDATE:** _____
HOME ADDRESS: _____ **HOME PHONE:** _____
EMAIL: _____ **CELL PHONE:** _____

We will not pass on your e-mail address to third parties. If you no longer wish to receive e-mails from us, you can cancel them at any time.

PREFERRED CONTACT METHOD (CIRCLE ONE): TEXT MESSAGING *(CDN NUMBERS ONLY)* **EMAIL PHONE CALL: □ Home □Cell**

FAMILY PHYSICIAN: _____ **MEDICAL SPECIALIST:** _____
MEDICAL ALERT: _____ **PHARMACY:** _____

1. Has there been any change in your health, such as illness or hospitalization?
   □ **YES, please specify** _____ □ **NO**

2. Are you taking any medications?
   □ **YES, please specify** _____ □ **NO**

3. Have you ever been prescribed Bisphosphonates for Jaw Disease, Cancer, Menopause or Osteoporosis?
   □ **YES, when?** _____ □ **NO**
   □ **Didronel (Etidronate)** □ **Aredia (Pamidronate)** □ **Fosomax (Alendronate)** □ **Actonel (Risedronate)**
   □ **Zometa (Zoledronate)** □ **Boniva (Ibandronate)** □ **Prolia (Denosumab)**

4. Do you smoke? □ **YES**, how much? _____ □ **NO** Do you chew tobacco? □ **YES**, how often? _____ □ **NO**
   Do you use cannabis? □ **YES**, how often? _____ □ **NO** Do you Vape? □ **YES**, how often? _____ □ **NO**

5. If you have ever had any of the following conditions, please mark the appropriate boxes:

□ **Stroke – Year:** _____	□ **Sleep Apnea**	□ **Seizures (Epilepsy)**	□ **Lung Disease**
□ **Heart Attack – Year:** _____	□ **Rheumatic Fever**	□ **Kidney Disease**	□ **Steroid Therapy**
□ **Leukemia – Year:** _____	□ **Liver disease**	□ **Arthritis**	□ **Hepatitis**
□ **Kidney Dialysis – Year:** _____	□ **Hypo Thyroid**	□ **Stomach ulcers**	□ **Tuberculosis**
□ **Prosthetic/artificial joints – Year:** _____	□ **Hyper Thyroid**	□ **Drug/alcohol dependency**	□ **Angina**
□ **Diabetes – last sugar reading** _____	□ **Pacemaker**	□ **Bleeding Disorder**	□ **Heart murmur**
□ **Malignant Hyperthermia**	□ **High blood pressure**	□ **Prosthetic heart valve**	□ **HIV/AIDS**
□ **Radiation – Last Tx:** _____	□ **Chest pain**	□ **Mitral Valve Prolapse**	□ **Asthma**
□ **Chemotherapy – Last Tx:** _____	□ **Fibromyalgia**	□ **Osteoporosis**	□ **ADHD/ADD**
□ **Cancer–Type:** _____ **Year:** _____	□ **MRSA**	□ **High Cholesterol**	□ **Autism**
□ **Acid Reflux/GERD**			□ **Anxiety**

6. Do you have or have had any conditions not listed above? □ **YES**, please specify _____ □ **NO**

7. When was your last medical check-up with your family physician? _____
   Were any problems identified? □ **YES**, please specify _____ □ **NO**

8. Do you have any allergies? □ **YES** □ **NO** **a) medications** **b) latex/rubber products** **c) other (hay fever, foods)**
   If yes, please list. _____

9. Have you ever been advised by your doctor to take prophylactic antibiotics before your dental treatment due to heart conditions or joint replacement? □ **YES** □ **NO**

10. Do you have any conditions or therapies that could affect your immune system?
    □ **YES please explain.** _____ □ **NO**

11. **For women only:** Are you pregnant? □ **YES/DUE DATE:** _____ □ **NO** □ **NOT SURE/MAYBE**
    Are you breast feeding? □ **YES** □ **NO**

To the best of my knowledge, the above information is correct.

PATIENT/PARENT SIGNATURE: _____ **DATE**: _____