Confidential health Questionnaire

Name: _____ **Age**: _____**Weight**: _____ **Height**: _____

1. Are you being treated for any condition? Yes No

Please write the condition_____

2. Please list previous surgery._____

3. Do you have anxiety about dental treatment? Yes No
4. Do you bleed excessively after a cut or tooth extraction Yes No
5. Have you ever required a blood transfusion? Yes No
6. Do you smoke? If yes, how much?_____ Yes No
7. Do you use drugs socially? If yes, which ones?_____ Yes No
8. Are you recovering from alcohol or drug addiction? _____ Yes No
9. Have you been exposed to or carry the HIV virus? _____ Yes No
10. Are you taking **medication**? If yes, please list._____ Yes No

_____

12. Do you have **allergies** to any medications? Yes No

If yes, please describe. _____

Penicillin	Yes No	Morphine	Yes No
Erythromycin	Yes No	Fentanyl	Yes No
Clindamycin	Yes No	Midazolam	Yes No
ASA	Yes No	Local anaesthetic	Yes No
Ibuprofen	Yes No	General anaesthetic	Yes No
Codeine	Yes No	Other medications	Yes No_____
Demerol	Yes No	Latex	Yes No

Do you have any of the following:

1. Tendency to feel faint Yes No
2 Sinus trouble Yes No
3. Thyroid problems Yes No
4. Kidney disease. Please describe _____ Yes No
5. Liver disease. Please describe_____ Yes No
6. Hepatitis. If yes, what type? A B C other (circle one) Yes No
7. Stomach problems or ulcer Yes No
8. Sleep apnea Yes No
9. Shortness of breath Yes No
10. Bronchitis Yes No
11. Asthma Yes No
12. Emphysema Yes No
13. Tuberculosis Yes No
14. Heart murmur Yes No
15. Rheumatic fever Yes No
16. Palpitations or rapid heart beat Yes No
17. Heart attack. If so, when? _____ Yes No
18. Congenital heart disease. If so, what? _____ Yes No
19. Pacemaker Yes No
20. Artificial heart valve Yes No
20. Stroke. If so, when? _____ Yes No
21. Arthritis Yes No

22. Artificial hip or joint Yes No
23. Organ transplant. Please describe_____Yes No
24. Creutzfeldt-Jakob disease (CJD) or variant Yes No
25. Family history of CJD Yes No
26. Epilepsy. If so, when was the last seizure?_____Yes No
27. Multiple Sclerosis Yes No
28. Diabetes Yes No
28. Anaemia Yes No
29. Glaucoma Yes No
30. Malignant tumour or cancer. If yes, please describe ._____ Yes No
31. Radiation to your face or jaws for cancer. If so, when? _____ Yes No
32. TMJ (jaw joint) problems. If yes please describe. _____ Yes No

Women only:

1. Are you pregnant? If so, what month?_____Yes No
2. Are you breast-feeding? Yes No

I certify that the above is true to the best of my knowledge.

Signature:_____ Date:_____

Next of kin_____ Phone: _____
_____

Medical history update 1. _____ _____ _____

update 2. _____ _____ _____
Signature Date Doctor signature

Consent for the collection and use of personal health information:

I, _____ acknowledge the Saskatchewan Health Information Protection Act and I understand my rights of privacy with respect to my personal information.
I further consent to the collection, use and disclosure of my personal information for the following purposes:

1. **To provide me with dental health service.**
2. **Referral to another health professional or medical or dental specialist if required.**
3. **To maintain communications and provide me with information and follow up regarding my dental care.**
4. **To obtain payment of my account.**
5. **For the uses and disclosures described in the privacy act.**

Signature: _____

If under 18 years of age:

Name of parent or guardian: _____

Signature of parent or guardian: _____