First Nations Health Authority
Health through wellness

Medical and Dental History

Authorization for Dental Treatment

Name: _____ Date of Birth: _____/_____/_____
Legal First Name Legal Last Name DD MM YYYY

Preferred Name (if different than above): _____
Preferred First Name Preferred Last Name

Gender: ☐ Male ☐ Female ☐ _____ ☐ Prefer not to say Status #: _____

Home Address: _____ Email: _____

Phone # (home): _____ (cell): _____ Message #: _____

Preferred Method of Contact (**circle one**): **Phone call / Text / Email / Other:** _____

Emergency Contact (name): _____ Emergency Contact Phone #: _____

Doctor's Name: _____ Doctor Phone #: _____

Address: _____

Medical History Questions

Please answer all questions to the best of your ability. Some of the questions may be uncomfortable to answer. All answers will be kept strictly confidential and are only asked so we can provide you with the best care possible.

Please mark **Yes** or **No** with a ✔ or ✖ it applies to you:

1) Do you have a doctor/nurse that you see regularly? ☐ **Yes** ☐ **No**

2) What is the name of the doctor/nurse or clinic that you usually go to? _____

3) When was the last time you saw the doctor/nurse (approximate date)? _____

4) What was the purpose of your last visit to the doctor/nurse? _____

5) Do you see the doctor/nurse regularly *for any medical reason*? ☐ **Yes** ☐ **No** ☐ **Unsure**
If yes, what is the medical reason for which you are seeing them? _____
_____

6) Do you take any medications, supplements, vitamins, or herbal remedies? ☐ **Yes** ☐ **No**
If yes, what medications, supplements, vitamins, or herbal remedies are you taking?
_____ _____
_____ _____
_____ _____

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7) So we can be sensitive to your needs, please consider telling us of any unpleasant or traumatic experiences that may affect your dental visits: _____
_____

8) Have you ever stayed in a hospital, had a serious illness, or undergone an operation? ☐ **Yes** ☐ **No**
If yes, what was the problem or illness? _____

9) Do you have **ANY** allergies or sensitivities (e.g. medications or antibiotics, anesthetics, metals, foods, latex, sodium lauryl sulfate, etc.)? ☐ **Yes** ☐ **No** ☐ **Unsure**
If yes, what are they? _____
If yes, please describe what happened to make you feel you had an allergy or sensitivity:
_____

10) Do you bleed excessively or bruise easily? ☐ **Yes** ☐ **No**

11) If you are cut or bruised, does it take a long time to heal? ☐ **Yes** ☐ **No**

12) Are you pregnant or think you might be pregnant? ☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **N/A**

13) Are you breastfeeding? ☐ **Yes** ☐ **No** ☐ **N/A**

The next few questions are important to answer because many substances can affect your overall and dental health. All answers are confidential and are not shared with anyone who is not part of providing your dental care.

14) Do you smoke or use any tobacco or marijuana-related products?
If yes, what type of product(s) do you use (e.g. chewing tobacco, cigarettes, cigars, marijuana, e-cigarettes, vaping products, other)? _____
How often (daily/weekly/monthly)? _____ How much? _____ For how long (years/months)? _____

15) Do you drink alcohol?
If yes, how often (daily/weekly/monthly)? _____ How much? _____ For how long (years/months)? _____

16) Do you use any street or recreational drugs?
If yes, what type? _____
How often (daily/weekly/monthly)? _____ How much? _____ For how long (years/months)? _____

17) Do you have or have you ever had any of the following (check all that apply)?

☐ Heart Disease
☐ Heart Murmur
☐ Scarlet Fever
☐ Asthma
☐ Hay Fever
☐ Fainting Spells
☐ Sexually Transmitted Infection
☐ Kidney Disease
☐ Epilepsy (seizures)
☐ Diabetes
☐ Liver Disease
☐ Lung Disease
☐ Pneumonia/Tuberculosis (TB)
☐ HIV/AIDS
☐ Stroke
☐ Mental/Nervous Disorders
☐ Alcohol/Drug Dependency
☐ Arthritis/Rheumatism
☐ Artificial Joints/Valves
☐ Blood Transfusions
☐ Cancer/Radiotherapy/Chemotherapy
☐ Eating Disorders (Anorexia/Bulimia)
☐ High/Low Blood Pressure
☐ Hyper/Hypoglycemia (High/Low Blood Sugar)
☐ Congenital Heart Defects
☐ Sleep Apnea
☐ Hepatitis (jaundice)
☐ Other: _____

Comments: _____

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Dental History Questions

18) When was your last dental visit (approximate date)? _____

19) Have you ever required antibiotics prior to dental treatment? ☐ **Yes** ☐ **No** ☐ **Unsure**

20) Have you ever had local anesthetic (freezing)? ☐ **Yes** ☐ **No**
If yes, did the freezing make you feel unwell? ☐ **Yes** ☐ **No**

21) What are your main dental concerns? _____
_____

Comments: _____
_____

I have answered all medical and dental history questions to the best of my knowledge.

Client full name (please print): _____

If client is a minor, parent/guardian/proxy full name (please print): _____

If proxy, what is your relationship to client? _____

Client/Proxy Signature: _____

Date (DD/MM/YYYY): _____/_____/_____

Clinician's Initials: _____