Dr. Omar Abdulghafoor, DDS
Dr. Ruba Al-Luaibi, DDS
Dr. Firas Elias, DDS
15-1455 Lakeshore Rd,
Burlington, ON
L7S-2J1, (905) 681-6588
harbourviewdentalclinic@gmail.com

Medical and Dental History

The information that you provide is essential to providing you with the best quality of dental care. The protection of your privacy and personal information is important to us and we are committed to collecting, using and disclosing this information responsibly. We will never share any of your information with a third party, unless given direct permission from you.

Contact Information:

Date: _____ How were you referred to Harbourview Dental? : _____

Patient is a(n): ☐ ADULT ☐CHILD ☐ ADULT UNDER GUARDIANSHIP and if so, NAME OF GUARDIAN:_____

First Name: _____ Last Name:_____ ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss

Nickname (Preferred to be called):_____ Language Preference:_____

Street Address: _____ Apt#:_____ City:_____ Province:_____ Postal Code:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Which number do you prefer we call you at?: _____ Email: _____

Date of Birth: Month:_____ Day: _____ Year_____ Age:_____ Sex:_____ Marital Status: _____ Name of Spouse:_____

In Case of Emergency:

We should contact:_____ Relationship:_____ Phone:_____

Family Physician: _____ Phone:_____

Medical Specialist, if under care: _____ Phone:_____

Dental History:

Date of last dental visit:_____ Last Cleaning:_____ Last x-rays:_____

Is there a problem you would like treated immediately: _____ ☐ Yes ☐ No

Have you ever had periodontal treatment? (treatment of the gums) _____ ☐ Yes ☐ No

Have you ever had orthodontic treatment? (straighten or align teeth) _____ ☐ Yes ☐ No

Have you ever had oral surgery: _____ ☐ Yes ☐ No

Have you noticed any loose teeth?: _____ ☐ Yes ☐ No

Does food catch between your teeth?: _____ ☐ Yes ☐ No

Are any of your teeth sensitive to hot, cold, sweets or pressure?: _____ ☐ Yes ☐ No

Have you ever been advised to take an antibiotic premedication before dental appointments?: _____ ☐ Yes ☐ No

Do you have any problems with your jaw joint such as pain, popping, grinding or clicking?: _____ ☐ Yes ☐ No

Do you clench or grind your teeth while awake or asleep?: _____ ☐ Yes ☐ No

Do you have any anxiety about dental treatment?: _____ ☐ Yes ☐ No

Have you ever had complications during/after dental treatment?: _____ ☐ Yes ☐ No

Is there anything you would like to change about your teeth or their appearance?: _____ ☐ Yes ☐ No

Do you feel that your dental health impacts your overall health?: _____ ☐ Yes ☐ No

Do your gums bleed while eating/brushing or do you suffer from pain and swelling of the gums?: _____ ☐ Yes ☐ No

Do you use floss, proxabrush or stimudents? How often?: _____ ☐ Yes ☐ No

How often do you brush your teeth?: _____

On a scale of 1-10, how important is it for you to retain your natural teeth? (Not Very) 1 2 3 4 5 6 7 8 9 10 (Very)

Medical History:

Are you being treated for ANY medical condition at present or within the last two years? _____ ☐ Yes ☐ No

If yes, please explain:_____

Treating Physician's name: _____ Phone Number:_____

Have you been hospitalized in the past two years?: _____ ☐ Yes ☐ No

Please list any surgeries you have had in the past:_____

_____

Please list ANY prescription or non prescription drugs or supplements:

1. _____ 2. _____ 3. _____

4. _____ 5._____ 6. _____

Do you have allergies to any medications? _____

Have you ever reacted negatively to ANY medications or injections? _____

Have you ever been advised against taking a specific medication? _____

Do you have any of the following? : Asthma, hay fever, skin rashes, hives, food, metal, latex allergies? _____

Do you have any other allergic conditions? _____

Do any of these allergies result in headache, nausea, swelling, shortness of breath or chest restriction? _____

Is there a family history of diabetes, cancer or heart disease? _____

Do you bleed EXCESSIVELY from a cut or bruise easily? _____

Do your ankles, hands or feet swell? _____

Do you experience shortness of breath or chest pain when climbing stairs? _____

Have you ever tested positive for HIV or Hepatitis A, B, or C? _____

Do you have any hearing difficulty? _____

Do you smoke or use other forms of tobacco? _____

Are you in the process of quitting smoking and using any aids or medication? _____

Are you, or have you ever been, alcohol or drug dependant? _____

Indicate if you HAVE or HAVE EVER HAD any of the following:

AIDS..... ☐ Yes ☐ No	Glandular Disorders..... ☐Yes ☐No	Lupus..... ☐ Yes ☐No
Anemia..... ☐ Yes ☐ No	Glaucoma..... ☐Yes ☐No	Malignant Hyperthermia..... ☐ Yes ☐No
Angina Pectoris..... ☐ Yes ☐ No	Head/Neck Injury..... ☐Yes ☐No	Mental/Nervous Disorder..... ☐ Yes ☐No
Arthritis/Rheumatism..... ☐ Yes ☐ No	Heart Disease/Attack..... ☐ Yes ☐No	Mitral Valve Prolapse..... ☐ Yes ☐No
Artificial Heart Valve..... ☐ Yes ☐ No	Heart Murmur..... ☐Yes ☐No	Organ Transplant..... ☐Yes ☐No
Artificial Joints..... ☐ Yes ☐ No	Heart Pacemaker..... ☐Yes ☐No	Psychiatric Treatment..... ☐ Yes ☐No
Blood Disorders..... ☐ Yes ☐ No	Heart Rhythm Disorder..... ☐Yes ☐No	Radiation/Chemotherapy..... ☐ Yes ☐No
Bronchitis..... ☐ Yes ☐No	Heart Surgery..... ☐Yes ☐No	Scarlet/Rheumatic Fever..... ☐ Yes ☐No
Cancer..... ☐ Yes ☐No	Hepatitis A B C..... ☐Yes ☐No	Sickle Cell Disease..... ☐ Yes ☐No
Circulation Problems..... ☐ Yes ☐No	Herpes..... ☐Yes ☐No	Sinus Trouble..... ☐ Yes ☐No
Congenital Heart Disease..... ☐ Yes ☐No	High/Low Blood Pressure..... ☐Yes ☐No	Stomach Problems..... ☐ Yes ☐No
Cortisone/Steroid Use..... ☐ Yes ☐No	Hyper/Hypo Glycemia..... ☐Yes ☐No	Stroke..... ☐ Yes ☐No
Crohn's Disease..... ☐ Yes ☐No	Hypertension..... ☐Yes ☐No	Thyroid Disease..... ☐ Yes ☐No
Diabetes..... ☐ Yes ☐No	Inflammatory Bowel Disease... ☐Yes ☐No	Tuberculosis..... ☐Yes ☐No
Emphasema..... ☐ Yes ☐No	Kidney Disease..... ☐Yes ☐No	Venereal Disease..... ☐Yes ☐No
Epilepsy/Seizures..... ☐ Yes ☐No	Liver Disease..... ☐Yes ☐No	Other:
Fainting/Dizzy Spells..... ☐ Yes ☐No	Lung Disease..... ☐Yes ☐No	Other:

For CHILD patients only:

Has the patient recently had: (please list approximate date)

Measles:_____ Mumps: _____ Chicken Pox: _____ Strep Throat: _____ Tonsilitus: _____

For WOMEN patients only:

Are you pregnant or suspect you may be? _____ Are you breastfeeding? _____ Are you using birth control medication? _____

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General Release:

I, _____ certify that I have provided an accurate and complete personal history and have not knowingly omitted any information. Should there be any change in my health or any other information that I provided, I will notify Harbourview Dental.

_____ _____

(Signature) ☐ **Patient** ☐ **Parent** ☐ **Guardian** **(Date)**