Wolfville Dentistry

Name: _____ Date of Birth (d/m/y) _____

Gender: ☐ Female ☐ Male ☐ Other Preferred pronoun:_____

Address: _____

Town: _____ Province: _____ Postal Code: _____

Home Phone:_____ Cell: _____

Work:_____ Email:_____

Preference for Reminders (circle or check one): ☐ text ☐ email ☐ phone call

Spouse/Partner (if applicable): _____

Children at home (if applicable): _____

Emergency Contact: _____ Phone:_____

Physician: _____ Pharmacy: _____

1. Are you being treated for any health condition (by a physician, naturopath, osteopath, chiropractor, etc) at the present or within the last year? **If so, please elaborate.**

2. If you are taking any medications (including vitamins, supplements, birth control, daily aspirin, etc) **please list with dosages or attach a separate list:**

3. Females: Are you pregnant? Breast feeding? (circle which) ☐ Yes No ☐

4. Do you have any allergies? Please list: as applicable

☐ Medications (list) ☐ Latex ☐ Other

5. Do you have, or have you had any of the following conditions (check/circle all that apply)?

☐ COVID-19 ☐ suspected ☐ tested positive ☐ recovered
☐ Heart Disease (incl. history of heart attack)
☐ Congenital heart defect, prosthetic valves, heart transplant
☐ Stroke
☐ High blood pressure Controlled? ☐ ☐ Yes ☐ No
☐ Chest Pain
☐ Diabetes (circle type) ☐ Type I Type II ☐
☐ Blood or bleeding disorder
☐ Lung condition (incl. Asthma, COPD)
☐ Thyroid condition (circle or check one) ☐ overactive ☐ underactive
☐ Kidney disease
☐ Liver disease (incl. jaundice, hepatitis)

☐ Acid Reflux, GERD
☐ Eating Disorder (Anorexia or Bulemia)
☐ Infectious disease (ie: HIV, TB)
☐ Immunosuppressed (undergoing chemo, radiation, medication-induced)
☐ Cognitive impairment (including dementia, Alzheimer's)
☐ Seizures
☐ Alcohol Use - average drinks per week _____
☐ Smoker/Vaper ☐ cigarettes ☐ marijuana ☐ Vape

6. Is there anything else you feel we should know about your overall health?

7. Do you have any **DENTAL CONCERNS** that you would like addressed today (please describe):

8. Do you have any areas causing you pain to pressure, hot/cold, sweets? ☐ Yes ☐ No

a) Please describe where (top/bottom/left/right/jaw/teeth):

b) Please describe what causes the pain (ie: pressure, chewing, temperature, spontaneous):

c) How long does it last (check)? ☐ seconds ☐ minutes ☐ hours ☐ non-stop

d) Please describe the discomfort (check): ☐ sharp/shooting ☐ dull/aching ☐ pulsing

9. Any recent increase in headaches, neck pain? ☐ Yes ☐ No

10. Have you been told you grind your teeth? ☐ Yes ☐ No

11. Have you had any recent increase in stress? ☐ Yes ☐ No

12. How would you rate your stress out of 10 (1=low; 10= very high) _____

13. Are you nervous during dental treatment? ☐ Yes ☐ No

14. Have you ever had a bad reaction to local anesthetic used in dentistry ("freezing")? ☐ Yes ☐ No

15. What is your home care routine? Brush ___ /day ☐ electric/manual ☐ Floss ☐ Rinse

16. Do you wear one of the following (check all that apply):

Denture	Nightguard/biteplane	Retainer
☐ Upper	☐ Upper	☐ Upper
☐ Lower	☐ Lower	☐ Lower

Patient Signature: _____ Date: _____

Office use only: ☐ **Allergy** ☐ **Pre-med** ☐ **Latex** ☐ **Epi**

COVID screening confirmed (Date/initial) _____ _____ _____ _____