GTA Periodontics & Dental Implants
Dr. Eugene Kryshtalskyj
DDS, Dip Perio, MSc(perio), FRCD(C)

Dr. Eugene Kryshtalskyj, D.D.S., M.Sc., F.R.C.D. (C)
Periodontist

JANE-BLOOR CENTRE
SUITE 201-2 JANE STREET
TORONTO, ONTARIO M6S 4W3
TEL (416) 762-7444 | www.gtaperiodontics.com

CONFIDENTIAL MEDICAL & DENTAL QUESTIONNAIRE

NAME: MR. / MISS / MRS. / DR.

DATE OF BIRTH: (DAY/MONTH/YEAR) / /

ADDRESS (HOME):

Postal Code:

PHONE: ( )

ADDRESS (BUSINESS):

Postal Code:

PHONE: ( )

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALTY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALTY:

PHONE OR ADDRESS:

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last medical checkup? (DAY/MONTH/YEAR) / /

3. Has there been any change in your general health in the past year? If so, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. (Aspirin ?) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If yes, please list using the categories below: ❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) Medications (Penicillin, Codeine, L.A. ?) b) Latex/Rubber Products c) Other (e.g. Hayfever, Foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had an artificial heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina	❑ rheumatic fever	❑ pacemaker	❑ steroid therapy	❑ seizures (epilepsy)	❑ heart attack
❑ mitral valve prolapse	❑ lung disease	❑ diabetes	❑ kidney disease	❑ stroke	❑ thyroid disease
❑ tuberculosis	❑ stomach ulcers	❑ shortness of breath	❑ heart murmur	❑ cancer	❑ arthritis
❑ drug/alcohol dependency		❑ osteoporosis medications (e.g. Fosamax, Actonel)			

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

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

PATIENT / PARENT / GUARDIAN SIGNATURE: **DATE:** / /

DENTIST SIGNATURE: **DATE:** / /

DENTIST'S NOTES

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DENTAL HISTORY

PATIENT'S NAME_____

DATE _____

1. Have you been under regular care by a dentist? [ ] YES [ ] NO
2. Have you ever had local anesthetic (freezing)? [ ] YES [ ] NO
3. Please specify if any complications_____
4. Have you ever had any teeth extracted including wisdom teeth? [ ] YES [ ] NO
   Please specify if any complications_____
5. Do any of your teeth ache hot/cold, sweetness, chewing [ ] YES [ ] NO
6. Do your gums bleed when you brush? [ ] YES [ ] NO
7. Do your gums feel tender or swollen? [ ] YES [ ] NO
8. Do you have any loose teeth? [ ] YES [ ] NO
9. Does food catch between your teeth? [ ] YES [ ] NO
10. Do you have problems chewing your food? [ ] YES [ ] NO
11. Has your jaw ever locked open or closed? [ ] YES [ ] NO
12. Do you grind your teeth at night or clench during the day? [ ] YES [ ] NO
12. What dental aids do you use for flossing and brushing your teeth? PLEASE CIRCLE
    Water pick, stimudents, rubber tip, and electric brush.
13. Have you ever had periodontal treatment? [ ] YES [ ] NO
14. Have you ever had orthodontics (tooth straightening) [ ] YES [ ] NO
15. Have you ever had major jaw or facial surgery, TMJ surgery
    Or dental implants? [ ] YES [ ] NO

CONSENT AND AUTHORIZATION

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

Signature_____ Date: _____