

# Pathways Dental Care

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Full Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone # \_\_\_\_\_ Medical Alert \_\_\_\_\_ Premedication \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Blood Pressure \_\_\_\_\_ HR \_\_\_\_\_ Referral Source \_\_\_\_\_  
Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_ M or F \_\_\_\_\_

## Medical History

Do you have or have you had any of the following, Please circle:

### Cardiovascular Health

Heart Disease/surgery  
Heart Attack  
Mitral valve prolapse  
Heart murmur  
Pacemaker  
Rheumatic fever  
Stroke  
Angina  
Cholesterol  
Blood Pressure High/Low  
Artificial valve  
Congenital heart disease

### Allergies

Latex  
Environmental  
Medications  
Anesthetic  
Other -

### Pregnancy

Oral contraceptives  
Pregnancy/Trying  
Menopause  
Fertility drugs  
Breast feeding

### Bones/Joints

Prosthetic joints  
Arthritis  
Medication

### Respiratory

Asthma  
Tuberculosis  
Shortness of breath  
Emphysema  
Sinus trouble

### Diabetes

T-1 Juvenile – Insulin  
T-2 Adult  
Stable  
Not Stable

### Social

Alcohol  
Tobacco/Smoking  
Diet  
Stress  
Nutritional supplements  
Nervousness

### Other

Bleeding/bruise  
Thyroid disease  
Liver Disease  
Hepatitis  
Cancer  
Immune Disease  
HIV/AIDS  
Anemia  
Kidney Disease  
Ulcers  
Glaucoma  
Epilepsy/seizures  
Fainting/dizzy spells

1. Has there been a change in your general health in the last year \_\_\_\_\_ YES NO
2. If so what is the condition you are being treated for? \_\_\_\_\_ YES NO
3. Have you been hospitalized or had a serious operation or illness within the last 5 years... YES NO
4. Are you taking any drugs or medications? \_\_\_\_\_ YES NO  
Please list on **Page 3 at top**
5. Do you have a disease, condition or problem not listed above that you think I should know? \_\_\_ YES NO  
If so, please explain \_\_\_\_\_
6. Do your ankles swell during the day? \_\_\_\_\_ YES NO
7. Can you walk up 2 flight of stairs without shortness of breath? \_\_\_\_\_ YES NO

## DENTAL HISTORY

How would you rate the condition of your mouth? \_\_ Excellent \_\_ Good \_\_ Fair \_\_ Poor  
Previous Dentist \_\_\_\_\_ How long had you been a patient? \_\_\_\_\_  
Date of most recent dental exam \_\_\_\_\_ Date of most recent X-Rays \_\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_\_  
I routinely see my dentist every: \_\_ 3 months \_\_ 4 months \_\_ 6 months \_\_ 12 months \_\_ not routinely  
WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

Please answer YES or NO to the following questions:

## PERSONAL HISTORY

1. Are you fearful of dental treatment? \_\_\_\_\_ YES NO
2. Have you had an unfavourable dental experience? \_\_\_\_\_ YES NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_ YES NO
4. Have you ever had trouble getting numb or had a reaction to local anesthetic? \_\_\_\_\_ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_ YES NO
6. Have you had any teeth removed? \_\_\_\_\_ YES NO

### GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_ YES NO  
8. Have you ever been treated for gum disease or been told you have lost bone around teeth? \_\_\_\_\_ YES NO  
9. Have you ever noticed an unpleasant taste or odour in your mouth? \_\_\_\_\_ YES NO  
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_ YES NO  
11. Have you ever experienced gum recession? \_\_\_\_\_ YES NO  
12. Have you ever had any teeth become loose on their own, or have difficulty eating an apple? \_\_\_\_\_ YES NO  
13. Have you experienced a burning sensation in your mouth? \_\_\_\_\_ YES NO

### TOOTH STRUCTURE

14. Have you had any cavities in the past three years? \_\_\_\_\_ YES NO  
15. Does the amount of saliva in your mouth seem too little, or have difficulty swallowing food? \_\_\_\_\_ YES NO  
16. Do you feel or notice any holes/pitting/craters on the biting surface of your teeth? \_\_\_\_\_ YES NO  
17. Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing part of your mouth? \_\_\_\_\_ YES NO  
18. Do you have any grooves or notches on your teeth near the gum line? \_\_\_\_\_ YES NO  
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? \_\_\_\_\_ YES NO  
20. Do you frequently get food caught between any teeth? \_\_\_\_\_ YES NO

### BITE AND JAW JOINT

21. Do you have problems with your jaw joint? pain, sounds, limited opening, locking? \_\_\_\_\_ YES NO  
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_ YES NO  
23. Do you avoid or have difficulty chewing gum or other hard dry foods? \_\_\_\_\_ YES NO  
24. Have your teeth changed in the last five years, become shorter, thinner, or worn? \_\_\_\_\_ YES NO  
25. Are your teeth becoming more crooked, crowded or overlapped? \_\_\_\_\_ YES NO  
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_ YES NO  
27. Do you have more than one bite, squeeze or shift your jaw to make your teeth fit together? \_\_\_\_\_ YES NO  
28. Do you place your tongue between your teeth or rest your teeth against your tongue? \_\_\_\_\_ YES NO  
29. Do you chew ice, bite your nails, use teeth to hold objects or have any other oral habits? \_\_\_\_\_ YES NO  
30. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_ YES NO  
31. Do you wake up with a headache or an awareness of your teeth? \_\_\_\_\_ YES NO  
32. Do you wear or have you ever worn, a bite appliance? \_\_\_\_\_ YES NO

### SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_ YES NO  
34. Have you ever whitened your teeth? \_\_\_\_\_ YES NO  
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_ YES NO  
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_ YES NO

### SLEEP HISTORY

37. Have you ever been diagnosed with a sleep disorder, had a sleep study or been told to get one? \_\_\_\_\_ YES NO  
38. Do you wake up in the morning feeling unrefreshed or catch yourself nodding off during day? \_\_\_\_\_ YES NO  
39. Do you feel tired, fatigued, sleepy during the daytime? Fall asleep driving or talking to someone? \_\_\_\_\_ YES NO  
40. Are you a restless sleeper? \_\_\_\_\_ YES NO  
41. Do you wake up frequently to urinate during the night? \_\_\_\_\_ YES NO  
42. Do you have a dry mouth or sore throat when you wake up? \_\_\_\_\_ YES NO  
43. Do you snore loudly, loud enough to be heard from another room? \_\_\_\_\_ YES NO  
44. Do you currently use, or have you ever used, a CPAP machine? \_\_\_\_\_ YES NO  
45. If yes, do you use your CPAP less than five times per week? \_\_\_\_\_ YES NO  
46. Have you tried CPAP and are looking for other treatment choices? \_\_\_\_\_ YES NO

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

