DR. DAVID RUSHKA INC.
GENERAL DENTISTRY

MEDICAL HISTORY

Name: _____ **Gender:** _____ **Birth Date (Y/M/D):** _____

Address:_____ **City:**_____ **Postal Code:** _____

Home #:_____ **Work #:** _____ **Cel #:** _____ **email:** _____

Care Card number: _____ **Family Physician:** _____

Previous Dentist: _____ **Emergency Contact & Telephone #:**_____

Who can we thank for referring you? _____

1. Have you ever had surgery? If so, for what reason and what year?

   _____

2. Have you been hospitalized or under the care of a physician within the last two years? If so, for what reason? _____
3. Are you currently taking any medications or tablets? If so, please list the medications and dosages:

   _____

4. Have you taken cortisone or steroids within the last 2 years? _____
5. Are you allergic or hypersensitive to anything, drugs or otherwise (e.g. Penicillin, latex, gluten, etc.)?

   _____

6. Have you or anyone in your family had problems with bleeding? _____
7. Do you or have you ever had: (Please circle)

☐ **ABNORMAL HEART CONDITION**	☐ **DIABETES**	☐ **EPILEPSY**
☐ **HIGH BLOOD PRESSURE**	☐ **TUBERCULOSIS**	☐ **ANEMIA**
☐ **PSYCHIATRIC TREATMENT**	☐ **RHEUMATIC FEVER**	☐ **ULCERS**
☐ **JAUNDICE OR HEPATITIS**	☐ **STI**	☐ **ARTHRITIS**
☐ **ASTHMA**	☐ **STROKE**	

8. Are you or might you be pregnant? _____
9. Have you ever had any serious illness? _____
10. Have you been advised that you may be at risk for HIV / Hepatitis? _____
11. Have you or anyone in your family had a problem with general or local anesthetic? If yes, what was the reaction? _____
12. Do you have a prosthetic heart valve, hip, knee or other prosthesis? _____
13. Do you smoke or use tobacco? If so, what and how much? _____

SIGNATURE: _____ **DATE:** _____

UPDATE:

20__/__/__: _____

20__/__/__: _____

20__/__/__: _____

20__/__/__: _____

DENTAL HISTORY

What is your immediate dental concern? _____

_____

When was your last check-up and cleaning appointment? _____

Have you ever had orthodontic treatment? If so, when? _____

Have you ever had periodontal (gum) treatment? If so, when? _____

Please check the box if you have, or are concerned about the following:

1. Displeasure with the appearance of your teeth ---------- ☐
2. A previous unfavorable dental experience ---------- ☐
3. Dental fears ---------- ☐
4. Problems with effectiveness or bad reactions to dental anesthetic------- ☐
5. Bleeding gums ---------- ☐
6. Areas of your mouth that you avoid brushing---------- ☐
7. Areas of your mouth which are sensitive to temperature ---------- ☐
8. Sore teeth ---------- ☐
9. A burning sensation in your mouth ---------- ☐
10. Jaw problems ---------- ☐
11. An unpleasant taste or odor in your mouth ---------- ☐
12. Difficulty opening your mouth widely ---------- ☐
13. Clicking or popping in your jaw ---------- ☐
14. Awakening with an awareness or your teeth or jaw ---------- ☐
15. Clenching or grinding of your teeth ---------- ☐
16. Missing teeth ---------- ☐
17. Food trapping between your teeth ---------- ☐
18. Tension headaches ---------- ☐
19. Stiff neck muscles ---------- ☐

SUPPLEMENTAL DENTURE HISTORY

If you wear a complete or partial denture, please complete the following:

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

YES	NO	(please check which is applicable)
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Has you present denture been relined? When? _____
☐	☐	Are you satisfied with its appearance?
☐	☐	Are you satisfied with its comfort?
☐	☐	Are you satisfied with its chewing ability?