Galiano Island Dental Clinic
Health Questionnaire

All information is confidential and not shared without your consent. Insight into your medical and dental conditions will
allow us to treat you safely.

Last Name First Middle	Date of Birth
Mailing address	Email Address
City/Province	Postal Code
Home Phone #	Cell Phone #
Name of Emergency Contact	Phone # of Emergency Contact

1. Have you been examined/treated by a medical doctor in the last year? yes no
   Name of Doctor, NP, or Alternative Practitioner _____ phone # _____
2. Have you ever been seriously ill or hospitalized? _____ yes no .5
3. Have you ever had abnormal bleeding with trauma, extraction, or surgery? yes no
4. Are you currently taking any medication or non-prescription drugs/supplements? yes no
   Please list here, or attach separate sheet. _____
   _____
5. Do you have any allergies? yes no Please specify _____
6. Have you ever been pre-medicated for dental treatment? yes no

Please check if you have or have had any of the following:

Rheumatic Fever	Thyroid Condition	Swollen Ankles
Heart Murmer	Arthritis	Heart Palpitations
Congenital Heart Condition	Inflammatory/Rheumatic Condition	Extra Pillows for Sleep, Sleep Apnea
Heart Attack	Cortisone/Steroid Treatment	Persistent Cough
Arteriosclerosis		Recent Change in Appetite
Stroke or TIA	Hives/Skin Rashes	Difficulty Swallowing
Angina Pectoris	Hay Fever	Frequent Indigestion, Vomiting
Blood Pressure Problems	Allergies	Gastroesophageal Reflux
Heart Trouble	Unusual Reaction to Drugs	Feel thirsty most of the time
Lung or Breathing Problems	Trouble with Dental Anesthesia	Urinate more than 6 times a day
Stomach/Intestinal Troubles		Painful, Swollen Joints
Hepatitis or Jaundice	Severe Headaches	Numb/Prickling Sensations
Diabetes	Chronic Sinus Trouble	History of Broken Bones
Blood Disorder	Chronic Sore Throat	Osteoporosis
Pacemaker/Artificial Valve	Chronic Ear Ache	Tendency to Faint
Infectious/Communicable Disease	Trouble Hearing	Seizures or Convulsions
HIV positive test	Hearing Aid	History of Family Disease
Covid-19 positive test	Prolonged Bleeding After Injury	Type of disease:
Tumours or Growths	Bruise Easily	For women:
Nervous/Mental Troubles	Shortness of Breath	Are you pregnant?
Epilepsy	Chest Pains	Past menopause
Tobacco Use	Any health concerns not listed:	

Non-prescription drug use		
Other		

Patient name: _____

Dental Information

Name of Previous Dentist _____ Phone Number _____
Date of last dental visit _____
Have you had annual regular dental care in the past? yes no

Please check those conditions that you have or have had:

Bleeding gums	Unpleasant dental experience	Root canal treatment
Sensitivity to cold	Reaction to local anesthetic	Denture or partial denture
Sensitivity to hot	Local anesthetic didn't work well	Orthodontic treatment
Teeth grinding	Allergic reaction to rubber dam	Surgery in your mouth
Teeth clenching	Claustrophobia	Details:
Nail biting	Gagging	Treatment by dental specialist
Sores or lumps in mouth	Need extra TLC	
Injury to face or jaw	Need extra cushioning	
Missing fillings	Panic attack	

How often do you brush your teeth? _____ How often do you floss? _____
What other oral hygiene products or devices do you use? _____

Are you satisfied with the function and appearance of your teeth? yes no
Have you had instruction in using dental floss? yes no

What dental conditions concern you now? _____

_____

Additional information that you think might be helpful: _____

_____

TREATMENT AUTHORIZATION
I, the undersigned, consent to the dental treatment agreed upon and understand that I am responsible for payment of the corresponding fees. I understand that the possibility of complications exists for each treatment.

Date: _____ Signature: _____

If you have dental insurance, please provide us with your identification card so we may copy it for our records.