Alberta Health Services

Last Name	
First Name	
PHN#	Birthdate *(yyyy-Mon-dd)*

Health Questionnaire for Dental Services

Parent/Guardianship/Spouse *(Last Name, First Name)*	Phone
Family Doctor's *(Last Name, First Name)*	Phone

How many children under age 18 do you have? _____

Please answer the following questions so the dentist can help you the best. This information is confidential.

Are you being treated by a family doctor now? ☐ No ☐ Yes ► _____

Have you ever had to stay in a hospital? ☐ No ☐ Yes ► _____

Have you ever had any serious illness or operation? ☐ No ☐ Yes ► _____

Are you taking any medicine or pills of any kind, including herbal medicines?
☐ No ☐ Yes ► _____

Are you allergic *(i.e. itching, rash, swelling of hands, feet or eyes)* or made sick by any medicines?
☐ No ☐ Yes ► ☐ Penicillin ☐ Anesthetic *(freezing)* ☐ Aspirin ☐ Codeine ☐ Other _____

Do you have problems with healing or prolonged bleeding? ☐ No ☐ Yes

Do you have or carry any infectious diseases? ☐ No ☐ Yes ► _____

Do you have or ever had any of the following?

☐ Heart Failure	☐ Brain Injury	☐ Asthma	☐ Chemotherapy
☐ Angina Pectoris	☐ Stroke	☐ Hay Fever	☐ Cancer/Leukemia
☐ Heart Surgery	☐ Frequent Headaches	☐ Sinus Trouble	☐ Radiation/Cobalt Treatment
☐ Heart Murmur	☐ Nervousness	☐ Hearing Loss	☐ Glaucoma
☐ Heart Pacemaker	☐ Epilepsy or Seizures	☐ Thyroid Problem	☐ Artificial Joint
☐ Heart Disease/Attack	☐ Psychiatric Treatment	☐ Diabetes	☐ Cortisone/Steroid Treatment
☐ Congenital Heart Problem	☐ High Blood Pressure	☐ Liver Problems	☐ Wheelchair Dependent
☐ Artificial Heart Valve	☐ Rheumatic Fever	☐ Arthritis/Rheumatism	☐ Emphysema
☐ Cold Sores	☐ Ulcers	☐ Allergies/Hives	☐ Mental/Physical Handicap
☐ Tuberculosis (TB)	☐ Venereal Disease Syphilis/Gonorrhea	☐ HIV/AIDS	☐ Anemia
☐ Hemophilia	☐ Bruise easily	☐ Sickle Cell Anemia	☐ Kidney Problem
☐ Blood Transfusion	☐ Yellow Jaundice	☐ Hepatitis	☐ Dialysis

☐ Other _____

Is there anything else about your health that we should know about? ☐ No ☐ Yes ► _____

Women: Are you pregnant? ☐ No ☐ Maybe ☐ Yes ► when is the due date *(yyyy-Mon-dd)*? _____

- To the best of my knowledge, all these answers are true and correct.
- If I have any change in my health, or if my medicines change, I will tell the dental staff at the first appointment afterwards.
- I will advise the dentist if I don't understand the dental procedures, anesthetics or X rays that are necessary for the dental treatment.
- I will pay the fees charged by the dental clinic.

Name *(Last, first)*	Signature	Date *(yyyy-Mon-dd)*	Reviewed by

Health information and personal information collected on this form will be used to process your application for Health Questionnaire for Dental Services. Collection of this information is authorized under section 20(b) of the Health Information Act and section 33(c) of the Freedom of Information and Protection of Privacy Act. In addition, AHS collects your personal health number under section 21(1)(a) of the Health Information Act. If you have any questions about this collection, please ask your care provider or contact Manager, Public Health Dental Services 6th Floor, 1213 4th Street SW Calgary, AB T2R 0X7; phone at 403.955.668 or email community.dental@ahs.ca

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