

THE COLLEGE OF DENTAL HYGIENISTS OF ONTARIO
69 Bloor Street East, Suite 300
Toronto, ON
M4W 1A9

CERTIFICATE OF REGISTRATION CLINICAL COMPETENCY EVALUATION

Name of Candidate: _____ Date: _____

HEALTH QUESTIONNAIRE

GENERAL INFORMATION

Surname:	Given Name:	Date of Birth:	Sex:
Address:		Telephone:	
Occupation:		Business:	
Physician:		Telephone:	
Dentist:		Telephone:	
In case of an emergency notify:		Telephone:	
General Assessment: (e.g. posture, breathing, anxiety)			

MEDICAL HISTORY

	Yes	No	Comment
1. Do you consider yourself to be in good health?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you been under the care of a physician during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	
3. During the last month have you taken or are you taking any medications? (List on back: name & does frequency)	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you on any special diet?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you lost or gained more than ten pounds during the last year?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you ever had any major operations?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever been seriously ill?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you had any X-Rays taken in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you received X-Ray or radioactive isotopes for treatment of disease?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you ever had heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
13. When you walk up stairs or walk a block, do you ever experience pain in the chest or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Do your ankles swell during the day?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you ever need more than two pillows to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Have you ever had rheumatic fever or rheumatic heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Have you ever had tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Do you have a kidney or a bladder problem?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are you pregnant now? How many weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Are you subject to fainting or dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Are you taking any medication for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Do you have malignant hyperthermia?	<input type="checkbox"/>	<input type="checkbox"/>	
25. Do you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Has a physician ever told you that you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you ever had severe nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Comments:
28. Have you ever had anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
29. Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	
30. Have you or any of your family ever had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
31. Have you ever taken thyroid tablets?	<input type="checkbox"/>	<input type="checkbox"/>	
32. Have you ever had jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
33. Do you have any allergies? To What? _____	<input type="checkbox"/>	<input type="checkbox"/>	
34. Have you ever had hives or a rash?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Are you sensitive to any particular medicine? Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
36. Have you ever had an adverse reaction to anaesthetic? Local <input type="checkbox"/> General <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Do you have arthritis? Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
38. Have you had Syphilis, Gonorrhoea or Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	
39. Have you ever had a joint replacement? Where & When: _____	<input type="checkbox"/>	<input type="checkbox"/>	
40. Are you HIV+?	<input type="checkbox"/>	<input type="checkbox"/>	
41. Do you breathe primarily through your mouth? Asthma? _____	<input type="checkbox"/>	<input type="checkbox"/>	
42. Do you ever get toothaches or gum boils?	<input type="checkbox"/>	<input type="checkbox"/>	
43. Do you ever get fever blisters or cold sores on your lips or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
44. Do you ever have pain opening or closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
45. Are you bothered by tooth sensitivity? HOT <input type="checkbox"/> COLD <input type="checkbox"/> SWEET <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
46. Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>	
47. Have you ever had "gum treatment"?	<input type="checkbox"/>	<input type="checkbox"/>	
48. Did you ever wear orthodontic bands?	<input type="checkbox"/>	<input type="checkbox"/>	
49. Have you ever experienced abnormal bleeding or severe pain following a tooth extraction?	<input type="checkbox"/>	<input type="checkbox"/>	
50. Have you visited your dentist in the last year? If not, how long ago?	<input type="checkbox"/>	<input type="checkbox"/>	
51. Do you feel nervous about having treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
52. Have you had any bad experiences in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>	
53. Do you have any disease problem not listed above? Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Medical History Comments: **BP:** _____ **Pulse:** _____

the above medical history is correct _____
(client/patient, parent, guardian)

MEDICAL HISTORY UPDATE /CHANGES

1. patient's general health _____
2. medication or drugs _____
3. visits to a physician _____
4. hospitalization _____
5. Blood Pressure: _____ Pulse: _____

Client Signature
Exams\Health Questionnaire

Date