Dr. Michael P. Shelegey

151 Bloor Street West, Suite 880 Toronto, Ontario M5S 1S4 Canada
T: (416) 962-7555 F: (416) 962-8242 www.drshelegey.com

Personal Data

First Name	Last Name	
Address	Apt.	
City	Province	Postal Code
Date of Birth [D/M/Y]	Place of Birth	
Home Phone	Business Phone	
Occupation	Company	
Referred by	Person responsible for account: Self ☐ Other	
Dental Insurance: No ☐ Yes ☐ Insurance Name		
S.I.N.	Group (Policy) No.	
Physician Name	Telephone	
In case of emergency please notify: Name		
Relationship	Telephone	

Dental History

1. Have you ever had a complete dental examination with a full series of x-rays of your teeth and jaw?	Yes ☐ No ☐
2. When was your last dental visit?	
3. What was done at that visit?	
4. Name of last dentist?	
5. Have you ever had local anaesthetic?	Yes ☐ No ☐
Any complications:	
6. Are any of your teeth sensitive to: Cold ☐ Sweets ☐ Heat ☐ Other ☐	
7. Do your gums bleen when: Brushing ☐ Flossing ☐ Spontaneously ☐	
8. Do your gums feel swollen or tender?	Yes ☐ No ☐
9. Do you catch food between your teeth?	Yes ☐ No ☐
10. Does your jaw crack, pop or grate when you open widely?	Yes ☐ No ☐
11. Do you grind or clench your teeth?	Yes ☐ No ☐
Dental Update:	

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Health Questionnaire

Are you in good health? Yes ☐ No ☐	Are you presently under the care of a physician? Yes ☐ No ☐
If so, for what?	
When was your last medical examination?	
When were you last admitted to hospital?	
Are you taking any medication? Yes ☐ No ☐	If so, what?
Are you allergic to penicillin? Yes ☐ No ☐	Are you allergic to any other drug? Yes ☐ No ☐
If so, for what?	
Are you a smoker? Yes ☐ No ☐	Do you drink alcohol? Yes ☐ No ☐
Has your physician ever told you to have antibiotics prior to dental procedures? Yes ☐ No ☐	
Have you ever had any complications following a medical or dental procedure? Yes ☐ No ☐	
FOR WOMEN ONLY: Do you take birth control pills? Yes ☐ No ☐	Are you pregnant? Yes ☐ No ☐

Please check all that apply

chest pain	Yes ☐ No ☐	swelling of ankles	Yes ☐ No ☐	tendency to bruise easily	Yes ☐ No ☐
sleeplessness	Yes ☐ No ☐	shortness of breath	Yes ☐ No ☐	difficulty breathing at night	Yes ☐ No ☐
weight loss	Yes ☐ No ☐	loss of appetite	Yes ☐ No ☐	low tolerance to hot / cold	Yes ☐ No ☐
persistent cough	Yes ☐ No ☐	excessive fatigue	Yes ☐ No ☐	reduced exercise tolerance	Yes ☐ No ☐

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Do you now, or have you ever had the following?

heart attack Yes ☐ No ☐	heart disease Yes ☐ No ☐	rheumatic fever Yes ☐ No ☐
heart murmur Yes ☐ No ☐	pace maker Yes ☐ No ☐	bleeding problems Yes ☐ No ☐
epilepsy Yes ☐ No ☐	stroke Yes ☐ No ☐	severe headaches Yes ☐ No ☐
glaucoma Yes ☐ No ☐	deafness Yes ☐ No ☐	nervous breakdown Yes ☐ No ☐
hay fever Yes ☐ No ☐	asthma Yes ☐ No ☐	sinus trouble Yes ☐ No ☐
allergies Yes ☐ No ☐	skin rash Yes ☐ No ☐	frequent colds Yes ☐ No ☐
emphysema Yes ☐ No ☐	tuberculosis Yes ☐ No ☐	lung disease Yes ☐ No ☐
ulcers Yes ☐ No ☐	diabetes Yes ☐ No ☐	kidney trouble Yes ☐ No ☐
arthritis Yes ☐ No ☐	steroids Yes ☐ No ☐	hip replacement Yes ☐ No ☐
cancer Yes ☐ No ☐	radiation Yes ☐ No ☐	chemotherapy Yes ☐ No ☐
jaundice Yes ☐ No ☐	hepatitis Yes ☐ No ☐	venereal disease Yes ☐ No ☐
neualgia Yes ☐ No ☐	major surgery Yes ☐ No ☐	serious accident Yes ☐ No ☐
heart valve replacement Yes ☐ No ☐	immune defiency disease Yes ☐ No ☐	other joint replacement Yes ☐ No ☐
mitral vale prolapse Yes ☐ No ☐	thyroid disease Yes ☐ No ☐	anemia or blood disorder Yes ☐ No ☐
high blood pressure Yes ☐ No ☐	gastrointestinal disease Yes ☐ No ☐	facial or jaw surgery Yes ☐ No ☐
fainting or dizzy spells Yes ☐ No ☐	arterio-venous shunt Yes ☐ No ☐	other serious illness Yes ☐ No ☐

Signature of Patient	Date
Please note: To avoid a cancellation fee - 48 Hour Notice is Required	
Signature of Patient	Date
Medical Update	