OKANAGAN SMILES

NEW PATIENT

Name: _____ **Date of Birth**: _____/_____/_____
MM DD YYYY

Occupation: _____

Are there any areas in your mouth hurting you? YES or NO If yes, please specify: _____

Do you have a specific concern you want the doctor to address first? _____

How long has this been a problem? _____

How many years since your last dental visit? _____ How many years since your last hygiene (cleaning)? _____

Is there anything you would like to change about your smile? _____

Please **CIRCLE** any services that may interest to you:

Orthodontics (Braces/Invisalign) Whitening Veneers Implants Dentures

MEDICAL QUESTIONS

Have you had any health problems in the past five (5) years? _____

Have you seen a physician or health care provider in the past two (2) years? YES or NO

Current Physicians' name: _____ Phone # or City: _____

Have you ever had surgery or hospital visit? YES or NO If yes, please specify: _____

Have you been advised to take antibiotics before dental appointments? YES or NO

Do you use tobacco products? YES or NO If yes, please specify type and amount per day:_____

Any other MEDICAL condition you think we should be aware of? _____

Please list ALL medications/multi-vitamins/supplements you are CURRENTLY taking and why you take them:

Medication	Reason for Use	Medication	Reason for Use
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

OFFICE USE ONLY	BP: mmHg	PULSE:

101-2149 Springfield Rd Kelowna, BC V1Y 7X1 t 250-763-3338 e hello@okanagansmiles.com w okanagansmiles.com
Dr. Vikram Grewal

Name: _____ **PLEASE CHECK ALL THAT APPLY**

HEART/BLOOD
- ☐ Congenital Heart Disease
- ☐ Rheumatic Fever
- ☐ Irregular or rapid heartbeat
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Stroke
- ☐ Endocarditis
- ☐ Joint replacement
- ☐ Problem with heart valve
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Heart Transplant
- ☐ Blood clots or thrombosis
- ☐ Anemia
- ☐ Sickle cell disease or trait
- ☐ Hemophilia
- ☐ Transfusion
- ☐ Other heart, vessel or blood disorder:

_____

HEAD & NECK
- ☐ Frequent or severe nosebleeds
- ☐ Difficulty swallowing
- ☐ Glaucoma
- ☐ Headaches
- ☐ Sinusitis
- ☐ Injuries to head, neck, jaw or teeth:

_____
- ☐ Other: _____

MUSCLES/BONES
- ☐ Sjogren's Syndrome
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Other: _____

URINARY TRACT
- ☐ Kidney Disease
- ☐ Renal Disease
- ☐ STD
- ☐ Other: _____

DIGESTIVE SYSTEM
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Jaundice
- ☐ Frequent heartburn
- ☐ Other: _____

RESPIRATORY
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Other: _____

ENDOCRINE
- ☐ Low thyroid
- ☐ Cushings Syndrome
- ☐ Parathyroid condition
- ☐ Diabetes
- ☐ Other: _____

NERVES
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple Sclerosis (MS)
- ☐ Trigeminal Neuralgia
- ☐ Chronic Pain
- ☐ Other: _____

MENTAL HEALTH
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment or counselling
- ☐ Other: _____

CANCER
- ☐ Leukemia
- ☐ Benign tumors/growths
- ☐ Other: _____
- ☐ Treatment: _____

ALLERGIES

Allergic reaction or bad reaction to:
- ☐ Dental anesthetics
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Latex
- ☐ Metals
- ☐ Other:_____

FAMILY HISTORY

Has anyone in your immediate family ever had:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Tuberculosis (TB)
- ☐ Depression
- ☐ Other: _____

OTHER
- ☐ HIV
- ☐ Organ Transplant
- ☐ Methamphetamine
- ☐ IV Drugs
- ☐ Herpes simplex (cold sores)
- ☐ Hepatitis A B C

WOMEN

Are you or is there a possibility that you may be pregnant?

YES or NO

Any form of birth control?

YES or NO

Initial please: _____

Name: _____

Please **CHECK** any of the following symptoms you may have:

HEAD AND FACE

- ☐ Pain in forehead
- ☐ Pain in temporal area
- ☐ Tension headaches
- ☐ Migraine headaches
- ☐ Sinus headaches
- ☐ Back of head headaches
- ☐ Hair, scalp tender to touch

NASAL

- ☐ Sinus pain
- ☐ Sinus problems
- ☐ Post nasal drainage
- ☐ Allergies

EYES

- ☐ Pain in/around eyes
- ☐ Bloodshot eyes
- ☐ Sensitive to light
- ☐ Tearing of eyes
- ☐ Blurred vision
- ☐ Pressure behind eye

EARS

- ☐ Ear pain without infection
- ☐ Decreased hearing
- ☐ Clogged, itchy or stuffy
- ☐ Ringing or buzzing
- ☐ Dizziness
- ☐ Balance problems

NECK

- ☐ Lack of mobility
- ☐ Stiffness
- ☐ Neck pain
- ☐ Tired or sore neck muscles
- ☐ Shoulder pain
- ☐ Back pain: middle, lower
- ☐ Arm or finger pain/numbness

THROAT

- ☐ Swallowing difficulties
- ☐ Feeling of foreign object in throat
- ☐ Sore throat without infection
- ☐ Voice changes
- ☐ Laryngitis
- ☐ Frequent coughing or clearing

MOUTH

- ☐ Abnormal opening
- ☐ Limited opening
- ☐ Bad bite
- ☐ Missing teeth
- ☐ Excessive mouth breathing
- ☐ Clench or grind teeth
- ☐ Mouth discomfort
- ☐ Inability to find “bite”

JAW (TMJ)

- ☐ Jaw pain
- ☐ Jaw joint pain
- ☐ Clicking or popping of jaw joint
- ☐ Grating sounds in jaw joint
- ☐ Pain in cheek muscles
- ☐ Uncontrollable jaw movements
- ☐ Jaw locks open/shut
- ☐ Deviates to one side on opening or closing

Date: _____

Signature:_____