

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M F Last Name: _____ First Name: _____

Address: No: _____ Street: _____ Apt: _____

City: _____ Postal Code: _____

Tel. Res.: _____ Work: _____ Cell: _____

Birthrate: Year: _____ Month: _____ Day: _____ E-mail: _____

Medicare No: _____ Expiry Date: _____ Social insurance No (optional) _____

If you are less then 18 years old, indicate name of parent or guardian _____

For an emergency contact: _____

Motive for visit: _____ Referred by: _____

MEDICAL HISTORY

Weight: _____ Height: _____

1. Are you presently under doctor care? Yes No
If so, reason: _____

Last Name: _____ First Name: _____

Tel: _____ (Ext.): _____

2. Are you presently taking any drugs or medication, or have you taken any in the last six months? Yes No
If so, which: _____

3. Are you presently natural or homeopathic products? Yes No
Specify: _____

Birth control pills: _____

Hormones: Specify: _____

4. Did you recently experience a significant weight loss or gain Yes No

5. Are you pregnant? Yes No
Are you breast feeding Yes No
Are you suffering or have you ever suffered from: _____

6. Heart disease (stroke, angina, valvular problems, murmur) Yes No

7. Rheumatic fever Yes No

8. Blood problems

8.1 Hemophilia Yes No

8.2 Prolonged bleeding Yes No

8.3 Clear Blood Yes No

8.4 Anemia Yes No

8.5 Other: Specify: Yes No

9. High Low Blood pressure Yes No

10. Frequent colds or sinusitis Yes No

11. Tuberculosis or lung problems Yes No

12. Digestive problems: Specify: Yes No

13. Stomach ulcer Yes No

14. Liver diseases (hepatitis A,B,C, cirrhosis, etc) Yes No

15. Kidney problems Yes No

16. Do you urinate often? Yes No

17. Venereal disease (V.D.) Yes No

18. Diabetes Yes No

19. Thyroid problems Yes No
20. Skin disease Yes No
21. Eye problems Yes No
22. Arthritis Yes No
23. Osteoporosis Yes No
Do you take bisphosphonates? Yes No
24. Epilepsy Yes No
25. Nervous disorder Yes No
26. Mental illness Yes No
Specify _____
27. Frequent headaches Yes No
28. Dizzy spells or fainting spells Yes No
29. Earaches Yes No
30. Hay fever Yes No
31. Asthma Yes No
32. Do you smoke? Yes No
33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor) Yes No
34. Do you have AIDS symptoms? Yes No
35. Are you an AIDS virus carrier? Yes No
36. Do you have artificial joints (knee, hip, etc.)? Yes No
37. Do you snore or have you ever been told that you snore? Yes No
38. Do you have any of the following allergies?

38.1 Latex	Yes <input type="checkbox"/> No <input type="checkbox"/>	38.6 Penicillin	Yes <input type="checkbox"/> No <input type="checkbox"/>
38.2 Food	Yes <input type="checkbox"/> No <input type="checkbox"/>	38.7 Codeine	Yes <input type="checkbox"/> No <input type="checkbox"/>
38.3 Iodine	Yes <input type="checkbox"/> No <input type="checkbox"/>	38.8 Other antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>
38.4 Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>	38.9 Local anesthesia	Yes <input type="checkbox"/> No <input type="checkbox"/>
38.5 Sulfonamides	Yes <input type="checkbox"/> No <input type="checkbox"/>	38.10 Others	Yes <input type="checkbox"/> No <input type="checkbox"/>

Specify: _____

39. Do you use drugs? Yes No
40. Do you drink alcohol? No/A little In moderation A lot
41. Were you ever hospitalized or have you undergone surgery Yes No
If so, why and then:

Date _____
Date _____
Date _____

42. Do you fear dental treatments? No/A little In moderation A lot
43. Is there anything concerning your health you wish to discuss privately with your dentist? Yes No
Remarks: _____

FOR THE PHYSICIAN'S USE ONLY

Precautions:

DENTAL HISTORY

Last visit: 0-6 months 6-12 months 12 months +

Treatments received: _____

1. Have you previously had dental treatments such as:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	7. Partial or/and complete denture	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Gum treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	8. Surgical treatment or extraction	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Orthodontic treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	9. Dental implants	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Root canal treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	10. X-rays	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Dental fillings	Yes <input type="checkbox"/>	No <input type="checkbox"/>	11. Others	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Crown or/and bridge	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

FOR THE PHYSICIAN'S USE ONLY

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures, as the case may be.

Signature: _____ Date: _____
Attending Dentist

TO BE COMPLETED BY PATIENT

I, the undersigned, hereby declare that I have read, understood and answered the above medical/dental questionnaire to the best of my knowledge. I also hereby promise to inform you any change to my health. I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my file will be kept in the office at all times and that only dentist(s) and his/her (their) auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

Signature: _____ Date: _____
Patient or Guardian