

CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

The information contained in the medical-dental questionnaire is necessary for the provision of dental care. Your dental record is protected by law and professional secrecy. It is kept in the office and only the dentist and authorized personnel may consult it and make entries.

Personal Information

First name _____
 Last name _____
 Gender F M X
 Date of birth _____ YY/MM/DD
 Health Ins. No. _____ Expiry YY/MM _____
 Address _____
 City _____
 Province _____ Postal code _____

Contact Information

Home tel. _____
 Work tel. _____
 Cell phone _____
 E-mail _____
For emergencies, call:
 Name _____
 Relationship to patient _____
 Main tel. _____
 Cell phone _____

Dental Information

Reason for today's visit _____
 Do you fear dental treatments?
 Not at all A little Very much
 Specify _____

Last visit 0-6 months 6-12 months + than 12 months
 Treatment(s) received _____ Yes No
 With panoramic radiographs (large x-ray)
 With intraoral radiographs (small x-rays)

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications. It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

Operative precautions—For use by the professional

Modification(s) _____ Date YY/MM/DD
 Modification(s) _____ Date YY/MM/DD
 Modification(s) _____ Date YY/MM/DD
 Modification(s) _____ Date YY/MM/DD

Medical history

- | | Yes | No |
|--|-----------------------|-----------------------|
| 1. Would you like to speak privately with your dentist? | <input type="radio"/> | <input type="radio"/> |
| 2. Are you being treated by a physician? | <input type="radio"/> | <input type="radio"/> |
| 3. Have you ever had surgery or been hospitalized? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you have joint prostheses (hip, knee, etc.)? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you gained or lost a lot of weight recently? | <input type="radio"/> | <input type="radio"/> |
| 6. Are you pregnant? | <input type="radio"/> | <input type="radio"/> |
| 7. Are you breastfeeding? | <input type="radio"/> | <input type="radio"/> |
| 8. Are you taking natural or homeopathic products? | <input type="radio"/> | <input type="radio"/> |
| 9. Are you taking medication? | <input type="radio"/> | <input type="radio"/> |
| 10. Are you taking birth control <input type="radio"/> or hormones <input type="radio"/> ? | <input type="radio"/> | <input type="radio"/> |

Reason, details and date

Specify _____

Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months

Medication and reason	Medication and reason

Please check Yes or No for each current or past condition

	Yes	No		Yes	No
Blood disorders			Skin diseases	<input type="radio"/>	<input type="radio"/>
(hemophilia, anemia, prolonged bleeding)	<input type="radio"/>	<input type="radio"/>	Eye disorders	<input type="radio"/>	<input type="radio"/>
Heart conditions			Earaches	<input type="radio"/>	<input type="radio"/>
Infarction (heart attack), angina, surgery, etc.	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Heart infection (endocarditis)	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>
Surgery to replace or repair a valve / cusp	<input type="radio"/>	<input type="radio"/>	Prevention / treatment (e.g.: tablets)	<input type="radio"/>	<input type="radio"/>
Blood pressure high <input type="radio"/> low <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Annual or monthly injection	<input type="radio"/>	<input type="radio"/>
Dizziness, fainting	<input type="radio"/>	<input type="radio"/>	Chronic pain	<input type="radio"/>	<input type="radio"/>
Frequent headaches	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>
Jaw pain	<input type="radio"/>	<input type="radio"/>	Nervous system disorders or diseases	<input type="radio"/>	<input type="radio"/>
Liver disorders (hepatitis A, B, C, cirrhosis, etc.)	<input type="radio"/>	<input type="radio"/>	Mental disorders or illnesses	<input type="radio"/>	<input type="radio"/>
Digestive system disorders or diseases	<input type="radio"/>	<input type="radio"/>	Frequent colds or sinusitis	<input type="radio"/>	<input type="radio"/>
Specify _____			Tuberculosis or lung disorders	<input type="radio"/>	<input type="radio"/>
Stomach disorders ulcer <input type="radio"/> reflux <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Kidney disorders	<input type="radio"/>	<input type="radio"/>	Hay fever / seasonal allergies	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Allergy or manifestation with products containing:		
Thyroid disorders	<input type="radio"/>	<input type="radio"/>	Latex	<input type="radio"/>	<input type="radio"/>
Cancer (tumour) Specify _____	<input type="radio"/>	<input type="radio"/>	Sulfonamides	<input type="radio"/>	<input type="radio"/>
Radiotherapy	<input type="radio"/>	<input type="radio"/>	Penicillin	<input type="radio"/>	<input type="radio"/>
Chemotherapy	<input type="radio"/>	<input type="radio"/>	Other antibiotics	<input type="radio"/>	<input type="radio"/>
Do you suffer from dry mouth?	<input type="radio"/>	<input type="radio"/>	Codeine	<input type="radio"/>	<input type="radio"/>
Sexually transmitted or blood-borne infections (STBBI)	<input type="radio"/>	<input type="radio"/>	Aspirin	<input type="radio"/>	<input type="radio"/>
Specify _____			Other medical conditions that should be mentioned:		

Other aspects

Have you ever been told that you snore or seem to stop breathing while you sleep?	<input type="radio"/>	<input type="radio"/>	Do you take other drugs?	<input type="radio"/>	<input type="radio"/>
Do you wake up tired in the morning and/or feel tired during the day?	<input type="radio"/>	<input type="radio"/>	Do you take methadone?	<input type="radio"/>	<input type="radio"/>
Do you suffer from sleep apnea?	<input type="radio"/>	<input type="radio"/>	<p>Section reserved for the dentist's special notes</p>		
Do you smoke? ____ cig./day or ex-smoker <input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>			
Frequency: ____ drinks <input type="radio"/> /day <input type="radio"/> /week <input type="radio"/> /month	<input type="radio"/>	<input type="radio"/>			
Do you use cannabis?	<input type="radio"/>	<input type="radio"/>			

Consent and identification

I have filled out this medical-dental questionnaire to the best of my knowledge.

 Patient or authorized person's signature* Date YY/MM/DD

 Name in print

*If the patient is a minor under 14 years of age: the holder of parental authority (including the parent) or the guardian. If the patient is a minor aged 14 or over: the minor, the holder of parental authority (including the parent) or the guardian.

I have reviewed the medical-dental questionnaire and reported any changes in my health since the previous visit.

 Signature Date YY/MM/DD

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 Signature Date YY/MM/DD

 Signature Date YY/MM/DD