



CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Last name _____ First name _____ Sex: F ☐ M ☐
No. _____ Street _____ Apartment _____ City _____
Postal code _____ Telephone _____ Telephone (work) _____
Cell phone _____ Birthdate Y/M/D _____ Social Insurance No. (optional) _____
E-mail _____ Medicare No. _____ Expiry Date _____
For an emergency, contact _____ Telephone _____
Motive for visit _____ Referred by _____
If you are less than 18 years old, indicate name of parent/guardian _____ Parent ☐ Mrs. ☐
Guardian ☐ Mr. ☐

Medical history

Weight _____ Height _____ Family doctor _____ Telephone _____

1. Are you currently receiving care from a doctor? Yes ☐ No ☐ If so, why _____
First and last name of doctor _____ Telephone _____ Extension _____
2. Please specify whether you are currently taking medication or have taken medication in the last six months:

Reason	Name of the medication	Name of the doctor who prescribed it and telephone

	Yes	No		Yes	No
3. Are you presently taking natural or homeopathic products? ...	<input type="checkbox"/>	<input type="checkbox"/>	21. Eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Specify _____			22. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	23. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Hormones? Specify	<input type="checkbox"/>	<input type="checkbox"/>	Do you take bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you recently experience a significant weight loss or gain?	<input type="checkbox"/>	<input type="checkbox"/>	24. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	25. Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	26. Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Are you suffering or have you ever suffered from :			Specify _____		
6. Heart disease			27. Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
(stroke, angina, valvular problems, murmur)	<input type="checkbox"/>	<input type="checkbox"/>	28. Dizzy spells or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
7. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	29. Earaches	<input type="checkbox"/>	<input type="checkbox"/>
8. Blood problems :			30. Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
8.1 Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	31. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
8.2 Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
8.3 Clear blood	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had radiotherapy or/and		
8.4 Anemia	<input type="checkbox"/>	<input type="checkbox"/>	chemotherapy treatments (tumor)?	<input type="checkbox"/>	<input type="checkbox"/>
8.5 Others, specify	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have AIDS symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood pressure High <input type="checkbox"/> Low <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Are you an AIDS virus carrier?	<input type="checkbox"/>	<input type="checkbox"/>
10. Frequent colds or sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you have artificial joints (knee, hip, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Tuberculosis or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	37. Do you snore or have you ever been told that you snore?	<input type="checkbox"/>	<input type="checkbox"/>
12. Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you have any of the following allergies:		
Specify _____			38.1 Latex <input type="checkbox"/> <input type="checkbox"/>	38.6 Penicillin <input type="checkbox"/> <input type="checkbox"/>	
13. Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>	38.2 Food <input type="checkbox"/> <input type="checkbox"/>	38.7 Codeine <input type="checkbox"/> <input type="checkbox"/>	
14. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	38.3 Iodine <input type="checkbox"/> <input type="checkbox"/>	38.8 Other antibiotics <input type="checkbox"/> <input type="checkbox"/>	
15. Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	38.4 Aspirin <input type="checkbox"/> <input type="checkbox"/>	38.9 Local anaesthesia <input type="checkbox"/> <input type="checkbox"/>	
16. Do you urinate often?	<input type="checkbox"/>	<input type="checkbox"/>	38.5 Sulfonamides <input type="checkbox"/> <input type="checkbox"/>	38.10 Others <input type="checkbox"/> <input type="checkbox"/>	
17. Venereal disease (V.D.)	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____		
18. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
19. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
20. Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>

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Medical history (continued)

Yes No

Yes No

40. Do you drink alcohol ?

No/A little ☐ In moderation ☐ A lot ☐

41. Were you ever hospitalized or have you undergone surgery other than dental ? ☐ ☐

If so, why _____ Date _____

_____ Date _____

_____ Date _____

42. Do you fear dental treatments ?

Not at all ☐ A little ☐ A lot ☐

43. Is there anything concerning your health you wish to discuss privately with your dentist ? ☐ ☐

Remarks _____

Dental history

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

Treatments received _____

Have you previously had dental treatments such as

1. Oral hygiene instructions ☐ ☐

2. Gum treatment ☐ ☐

3. Orthodontic treatment ☐ ☐

4. Root canal treatment ☐ ☐

5. Dental fillings ☐ ☐

6. Crown or/and bridge ☐ ☐

Yes No

7. Partial or/and complete denture ☐ ☐

8. Surgical treatment or extraction ☐ ☐

9. Dental implants ☐ ☐

10. X-rays ☐ ☐

11. Others ☐ ☐

Yes No

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

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 of 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 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 of patient or guardian _____

Date _____

For the physician's use only

Precautions

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 of the attending dentist _____

Date _____