Medical and dental questionnaire (confidential)

Last name : _________________________ **Given name** : ____________________________

Personal address : ___________________________________ **City** : ___________________

Postal code : ______________ **You were refered to our clinic by** : ____________________

Residential phone : ( ) __________________ **Business phone** : ( ) __________________

Occupation : ___________________________ **Sex** : M___ W___

E-mail : _____________________________ **Emergency call : (**) ___________________

DATE OF BIRTH :		
Y	M	D

Medicare : __ __ __ __ __ __ __ __ __ __ __ __ expiration : __ __ / __ __.

Beneficiary of social aid Yes : No :

Do you have dental insurance Yes : No :
Policy # : __________________________________ Identification # : ______________________________
Insurance compagny : ____

In your own interest, it is necessary to answer all the following questions so that we may, before any treatment, gather all the necessary information in the orientation of a complete clinical examination with X-Rays, thus obtaining a diagnosis and a development of operative precautions, finally leading to the elaboration of a treatment plan.

If you do not understand a few questions, do not hesitate to ask for explanations.

MEDICAL HISTORY :	**YES**	**NO**
Are you snoring: ____	__	__
Do you have health problems? : _________________________________	__	__
Are you under a physician's care? : ______________________________	__	__
If so, specify : ____		
Do you take or have you taken medication over the last 12 months (pill and/or injection)? :______ ______________________________	__	__
If so, which one (s) : ____		
Date of your last medical check up : ______________________________		
Name of your physician : ________________________ Tel : ____________		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DIDEASES OR PROBLEMS :

	YES	**NO**		**YES**	**NO**
Sleep apnea (□ CPAP or □ mandibular Advancement device)	__	__	Digestive problems :	__	__
Allergies (medication or orthers) ou latex :	__	__	Fainting spells (vertigo) :	__	__
Heath disease :	__	__	Earaches (otitis, mumps) :	__	__
Endocarditis (rheumatic fever) :	__	__	Frequent headaches :	__	__
Coronary insufficiency :	__	__	Difficulty in breathing by the nose :	__	__
High __ Low __ blood pressure	__	__	Prolonged bleeding :	__	__
Swelling (abdomen, legs, ankles) :	__	__	Hemophilia :	__	__
Arteriosclerosis :	__	__	Diabetes :	__	__
Asthma :	__	__	Mononucleosis :	__	__
Prologed sore throat :	__	__	Tuberculosis :	__	__

	YES	NO		YES	NO
Other respiratory problems :	__	__	Eye problems (glaucoma __) :	__	__
Kidney disease :	__	__	Anaemia :	__	__
Liver disease (hepatitis __, cirrhosis __) :	__	__	Sexually transmitted dideases :	__	__
Nervous disease :	__	__	Acquired Immune Deficiency Syndrome :	__	__
Skin problems :	__	__	Arthritis, Osteoarthritis :	__	__
Epilepsy :	__	__	Frequent colds (ou sinusitis) :	__	__
Thyroid didease :	__	__	Other disease not mentionned above :	__	__
Blood transfusions :	__	__			

OTHER INFORMATION :

	YES	NO
Have you ever undergone radiotherapy (tumor) : ____ ____________	__	__
Do you smoke?: ____	__	__
Do you take drugs?: ____	__	__
Do you consume alcohol daily?____	__	__
Are you pregnant? : _________________ ____	__	__
Are you menopause?: ____	__	__

DENTAL HISTORY :

What is the motive of your visit today? : ____
Date of your last visit at the dentist? : ____
Name of previous dentist : ____
Date of last dental X-rays : ____
Do you feel any pain now? : ____
If so, what kind of pain? : Cold____ Hot____ Sugar ____ Pressure ____ Continually ____

Do you grind your teeth?: ____
When you wake up, is your jaw sensitive? ____
Have you ever had surgery on your jaw? ____
Have you had an orthodontic treatment (braces)? ____
Do you have the impression of having bad brealth? ____
Do you feel any dryness in your mouth? ____
Do your gums swell? ____
Are they sensitive and irrited? ____
Does the food get caught beetween your teeth? ____

If you haven't visited your dentist regularly, indicate the principal motive:

Fear of pain :	Cost of treatment :
Lack of interest :	Non availability (numerous obligations) :

I authorize the setting of my files (diagnosis, treatment and follow-up) and my registration on the recall list(s) of the treating dentist(s).
I have been informed that my file will be kept in the office at all times and that only the dentist(s) and hid/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 necessay, and to remove my name from the recall list.
I, the undersigned, declare that I have read, understood, been informed and also have answered this questionnaire to the best of my knowledge. I also acknowledge the importance of informing my treating dentist of all future changes concerning my health and the medication I will consume.

Important: You must inform us of any change in your medical condition.

Signature patient or responsible : ______________________________ Date : ___ / ___ / ___.