



## CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

First name	Personal Information	Contact Information
Last name  Sex F O M O Date of birth Health Ins. No. Expiry Health Ins. No. Expiry Frowince Province Postal code Obtained  City Relationship to patient Main tel. Cell phone  Cell phone  Cell phone  Reason for today's visit  Do you fear dental treatments? Not at all O A little O Very much O With panoramic radiographs (large x-ray) 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 patients best interest to carefully hill it out and notify the dentist of any change in their health condition  Blood disorders Infarction Theart attackl, angina, surgery, etc. Infarction Theart attackl, angina, surgery etc. Infarction Theart attackl, angina	First name	Home tel
Sex F O M O Cell phone		
Date of birth Health Ins. No. Expiry For emergencies, call: Address Name City Relationship to patient Main tet. Cett phone  Dental Information  Reason for today's visit Do you fear dental treatments? Not at all O A little O Very much O With panoramic radiographs (large x-ray) O With panoramic radiographs (small x-rays) O With intraoral radiographs (small x-rays) O With in		
Health Ins. No.   Expiry   For emergencies, catts   Address   Name   Selectionship to patient   Relationship to patient		
Address   Name   Relationship to patient   R		
Relationship to patient   Main tel.		
Province		
Reason for today's visit		
Reason for today's visit	Province Postal code	Main tel
Do you fear dental treatments?  Not at all   A little   Very much   With panoramic radiographs (large x-ray)   Specify   With intraoral radiographs (large x-ray)   Specify   With intraoral radiographs (small x-rays)   Specify   With intraoral radiographs (small x-rays)   Specify   Skin diseases   Skin	Dental Information	Cell phone
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Specify		With panoramic radiographs (large x-ray)
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.  Blood disorders  [hemophilia, anemia, prolonged bleeding]  Beart conditions  Infarction [heart attack], angina, surgery, etc.  Heart infection [endocarditis]  Surgery to replace or repair a valve /cusp  Blood pressure  high low  Dizziness, fainting  Frequent headaches  Jaw pain  Liver disorders (hepatitis A, B, C. cirrhosis, etc.)  Digestive system disorders or diseases  Specify  Stomach disorders ulcer reflux  Many disorders  Diabetes  Thyroid disorders  Cancer [tumourl Specify  Radiotherapy  Chemotherapy  Do you suffer from sleep apnea?  Do you ustreed drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?  Frequency:  drinks   //day   //week   //month    Do you drink alcohol?	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Heart conditions Infarction (heart atack), angina, surgery, etc. Infarction (heart atack), angina, surgery, etc. Heart infection (endocarditis)  Surgery to replace or repair a valve /cusp Dizziness, fainting Frequent headaches Jaw pain Liver disorders (hepatitis A, B, C. cirrhosis, etc.) Digestive system disorders or diseases Specify Stomach disorders Videy disorders Stomach disorders Thyroid disorders Cancer (tumour) Specify Radiotherapy Chemotherapy Do you suffer from dry mouth? Sexually transmitted or blood-borne infections (STBBI) Specify Other aspects Do you smore? Do you drink alcohol? Frequency: Gride of the dentist's special notes  Earaches Arthritis Osteoporosis Arthritis Osteoporosis Prevention (treatment (e.g.: tablets) Annual or monthly injection Chronic pain Prevous system disorders or diseases Specify Hervous system disorders or diseases Mental disorders or illnesses Mental disorders or illnesses Mental disorders or illnesses Frequent colds or sinustits Thyroid disorders Asthma Hay fever / seasonal allergies Altergy or manifestation with products containing: Latex Sulfonamides Penicillin Other antibiotics Pood Codeine I lodine-containing products Aspirin Other: Other medical conditions that should be mentioned:  Section reserved for the dentist's special notes  Section reserved for the dentist's special notes  Frequency: drinks //day //week //month Do you take drugs?	Blood disorders	Skin diseases
Infarction (heart attack), angina, surgery, etc.   Heart infection (endocarditis)   Osteoprosis		
Heart infection (endocarditis) Surgery to replace or repair a valve /cusp Blood pressure high low Annual or monthly injection Chronic pain Epilepsy Jaw pain Pervention / Chronic pain Epilepsy Jaw pain Nervous system disorders or diseases Annual disorders or diseases Mental disorders or illnesses Prequent colds or sinusitis Specify Tuberculosis or lung disorders Asthma Any fever / seasonal allergies Altergy or manifestation with products containing: Latex Sulfonamides Altergy or manifestation with products containing: Latex Sulfonamides Penicillin Anesthetic Other antibiotics Food Codeine Indinerontaining products Aspirin Other: Specify Other ansmitted or blood-borne infections (STBBI) Specify Other ansmitted or blood-borne infections (STBBI) Sexually transmitted or blood-borne infections (STBBI) Section reserved for the dentist's special notes  Do you surfer from sleep apnea? Do you sour sonce? Do you sonce? Do you sonce? Do you sonce? Do you drink alcohol? Frequency: drinks /day /week /month Op you take drugs?		Earaches
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Jaw pain Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	Dizziness, fainting	O Chronic pain
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)  Digestive system disorders or diseases  Specify  Stomach disorders  Kidney disorders  Diabetes  Thyroid disorders  Cancer (tumour) Specify  Radiotherapy Chemotherapy Do you suffer from dry mouth?  Sexually transmitted or blood-borne infections (STBBI)  Specify  Other aspects  Do you suffer from sleep apnea?  Do you sumake? cig./day or ex-smoker    Frequent colds or sinusitis  Tuberculosis or lung disorders  Ashtma  Hay fever / seasonal allergies  Altergy or manifestation with products containing:  Latex		
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Specify		O Frequent colds or sinusitis
Stomach disorders ulcer reflux Ashtma Hay fever / seasonal allergies Allergy or manifestation with products containing:  Latex Sulfonamides Penicillin Anesthetic Other antibiotics Food Codeine Iodine-containing products Aspirin Other:  Sexually transmitted or blood-borne infections (STBBI) Specify  Other aspects  Do you suffer from sleep apnea?  Do you suffer from sleep apnea?  Do you drink alcohol?  Frequency:drinks /day /week /month Do you take drugs?		
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Other aspects  Do you snore?		
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Frequency: drinks		
Do you take drugs?		
Do you take drugs?	· · ·	
	Do you take drugs?	

edical history	Yes No	)	
Would you like to speak privately with your dentist?	0 0	,	
Are you being treated by a physician?	0 0		
Have you ever had surgery or been hospitalized?	0 0		
Do you have joint prostheses (hip, knee, etc.)?	0 0		
Have you gained or lost a lot of weight recently?		6 Participal Milescope Store	
Are you pregnant? Are you breastfeeding?	0 0		
Are you taking natural or homeopathic products?		Specify	
Are you taking medication?	0 0	Specify	
Are you taking medication:  1. Are you taking birth control ○ or hormones ○ ?	0 0		
rase indicate all medication (including birth control and			r have taken in the last 12 months
Medication and reason			Medication and reason
		\$ N	
	Yes No		Ye:
Consent to communicate with a health professional Family physician, specialist, pharmacist, other		itlo	
Consent to communicate with a health professional		itle	Yes  Institution / telephone
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Patient