ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

Ordre des dentistes du Québec

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
3. Are you presently taking natural or homeopathic products?	☐	☐
Specify _____		
Birth control pills ?	☐	☐
Hormones ? Specify _____	☐	☐
4. Did you recently experience a significant weight loss or gain?	☐	☐
5. Are you pregnant ?	☐	☐
Are you breastfeeding?	☐	☐
Are you suffering or have you ever suffered from :		
6. Heart disease (stroke, angina, valvular problems, murmur)	☐	☐
7. Rheumatic fever	☐	☐
8. Blood problems :		
8.1 Hemophilia	☐	☐
8.2 Prolonged bleeding	☐	☐
8.3 Clear blood	☐	☐
8.4 Anemia	☐	☐
8.5 Others, specify _____	☐	☐
9. Blood pressure High ☐ Low ☐	☐	☐
10. Frequent colds or sinusitis	☐	☐
11. Tuberculosis or lung problems	☐	☐
12. Digestive problems	☐	☐
Specify _____		
13. Stomach ulcer	☐	☐
14. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	☐	☐
15. Kidney problems	☐	☐
16. Do you urinate often ?	☐	☐
17. Venereal disease (V.D.)	☐	☐
18. Diabetes	☐	☐
19. Thyroid problems	☐	☐
20. Skin disease	☐	☐

	Yes	No
21. Eye problems	☐	☐
22. Arthritis	☐	☐
23. Osteoporosis	☐	☐
Do you take bisphosphonates ?	☐	☐
24. Epilepsy	☐	☐
25. Nervous disorders	☐	☐
26. Mental illness	☐	☐
Specify _____		
27. Frequent headaches	☐	☐
28. Dizzy spells or fainting spells	☐	☐
29. Earaches	☐	☐
30. Hay fever	☐	☐
31. Asthma	☐	☐
32. Do you smoke ?	☐	☐
33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor) ?	☐	☐
34. Do you have AIDS symptoms ?	☐	☐
35. Are you an AIDS virus carrier ?	☐	☐
36. Do you have artificial joints (knee, hip, etc.) ?	☐	☐
37. Do you snore or have you ever been told that you snore ?	☐	☐
38. Do you have any of the following allergies :		
38.1 Latex	☐	☐
38.2 Food	☐	☐
38.3 Iodine	☐	☐
38.4 Aspirin	☐	☐
38.5 Sulfonamides	☐	☐
38.6 Penicillin	☐	☐
38.7 Codeine	☐	☐
38.8 Other antibiotics	☐	☐
38.9 Local anaesthesia	☐	☐
38.10 Others	☐	☐
Specify _____		
39. Do you use drugs ?	☐	☐

SEE REVERSE

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Medical history (continued) 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 ? Yes No
    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

	Yes	No		Yes	No
1. Oral hygiene instructions	☐	☐	7. Partial or/and complete denture	☐	☐
2. Gum treatment	☐	☐	8. Surgical treatment or extraction	☐	☐
3. Orthodontic treatment	☐	☐	9. Dental implants	☐	☐
4. Root canal treatment	☐	☐	10. X-rays	☐	☐
5. Dental fillings	☐	☐	11. Others	☐	☐
6. Crown or/and bridge	☐	☐			

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

2014-09