CLINIQUE DENTAIRE ST-LEONARD

ACDQ ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Ordre des dentistes du Québec

Sex : M☐ F☐ Last name : _____ First name : _____

Address : no : _____ Street : _____ Apt : _____ City : _____

Postal Code : _____ Tel. Res. _____ Work : _____ (Ext) : _____ E-mail : _____

Birthdate : Year : _____ Month : _____ Day : _____ Guardian : _____

Medicare no.: _____ Expiry Date:_____ Social Insurance no. (optional) : _____

For an emergency, contact: _____ Motive for visit: _____

MEDICAL HISTORY

Weight _____ Height _____

		Yes	No
1	Are you presently under a doctor's care?.....	☐	☐
	If yes : Last name :_____ First name :_____ Tel : _____ (Ext) : _____		
2	Are you presently taking any drugs or medication, or have you taken any in the last six months?..... If so, which: _____	☐	☐
3	Did you recently experience a significant weight loss or gain?.....	☐	☐
4	Are you pregnant?.....	☐	☐
5	Are you taking any birth control pill?.....	☐	☐
	Are you suffering or have you ever suffered from:		
6	Heart disease (stroke, angina, valvular, problems, murmur).....	☐	☐
7	Rheumatic fever	☐	☐
8	Prolonged bleeding	☐	☐
9	Anemia.....	☐	☐
10	High☐ Low☐ Blood pressure.....	☐	☐
11	Frequent colds or sinusitis	☐	☐
12	Tuberculosis or lung problems.....	☐	☐
13	Digestive problems.....	☐	☐
14	Stomach ulcer	☐	☐
15	Liver disease (hepatitis A, B, C, cirrhosis, etc.).....	☐	☐
16	Kidney disease.....	☐	☐
17	Venereal Disease (V.D.)	☐	☐
18	Diabetes.....	☐	☐
19	Thyroid problems.....	☐	☐
20	Skin disease	☐	☐
21	Eye problems.....	☐	☐
22	Arthritis.....	☐	☐
23	Epilepsy.....	☐	☐
24	Nervous disorders.....	☐	☐
25	Frequent headaches.....	☐	☐
26	Dizzy spells or fainting spells.....	☐	☐

		Yes	No
27	Earaches	☐	☐
28	Hay fever	☐	☐
29	Asthma.....	☐	☐
30	Do you smoke?.....	☐	☐
31	Have you ever had radiotherapy or/and chemotherapy treatments (tumor?.....	☐	☐
32	Do you had AIDS symptoms?.....	☐	☐
33	Are you an AIDS virus carrier?.....	☐	☐
34	Do you have artificial joints (knee, hip, etc).....	☐	☐
35	Do you have any of the following allergies?:		

	Yes	No		Yes	No
Food	☐	☐	Iodine	☐	☐
Aspirin	☐	☐	Sulfonamide	☐	☐
Penicillin	☐	☐	Codeine	☐	☐
Other antibiotics	☐	☐	Local anaesthesia	☐	☐
Specify :_____			Others :_____		

		Yes	No
36	Were you ever hospitalized or have you undergone surgery other than dental..... If so, indicate which one and when: _____ Date _____ _____ Date _____ _____ Date _____	☐	☐
37	Is there anything concerning your health you wish to discuss privately with your dentist?.....	☐	☐

FOR PHYSICIAN'S USE ONLY

PRECAUTIONS:

CLINIQUE DENTAIRE ST-LEONARD

DENTAL HISTORY

1. Date of the last dental visit? _____/_____/_____ Date of last dental x-rays? _____/_____/_____
2. Reason for last visit? _____
3. Do you have any concerns about previous dental care or this dental visit? _____
   _____
4. Do your gums bleed? (circle) Yes No
5. Are your teeth loose? (circle) Yes No
6. Have you ever been told you have gum disease? (circle) Yes No
7. Have you ever been told you have bad breath? (circle) Yes No
8. Are your teeth sensitive to? (circle all that apply) Sweets Cold Heat Pressure
9. Have you ever had any pain in your jaw joints (clicking, popping)? (circle) Yes No
10. Are you happy with your smile? (circle) Yes No
    If no, please explain: _____
11. What would you change about the present condition of your mouth? _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes tor updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print _____ Relationship _____

Signature _____ Date _____

FOR THE PHYSICIAN'S USE ONLY

I acknowledge that I have read the answers to the above questionnaire and that I have taken customary measures, as the case maybe.

Signature :_____ Date :_____
Attending dentist

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 changes to my health. I authorise the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of attending dentist(s). I have been informed that my file will be kept in the office at all times and only the dentist(s) and his/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 necessary, and to remove my name from the recall list.

Signature :_____
Date :_____
Patient or guardian