DENTAL FILE

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

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

Address: No.: _____ Street: _____ Apt.: _____ City: _____

Postal Code: _____ _____ Tel: Res.: _____ Work: _____ (Ext.) _____

Date of Birth: Day _____ Month _____ Year _____ Marital Status: _____ Weight: _____ Height: _____

Guardian: _____

Medicare No.: _____ – _____ – _____ Exp.: _____

Cell: _____

Referred by: _____

E-mail: _____

REASON FOR VISIT: _____

MEDICAL HISTORY

1. Are presently under a physician's care?

If yes:

Last Name _____ First Name _____

Tel.: _____ (Ext.) _____

	YES	NO
2. Are you presently taking any drugs or medication, or have you taken any in the last 6 months?	☐	☐
If yes, which? _____		
3. Are you pregnant?	☐	☐
4. Are you taking any birth control pill?	☐	☐
Are you suffering or have you ever suffered from .....?		
5. Heart disease (stroke, angina, murmur, valvular problems)	☐	☐
6. Rheumatic fever	☐	☐
7. Prolonged bleeding	☐	☐
8. Anemia	☐	☐
9. High ☐ Low ☐ Blood pressure	☐	☐
10. Frequent colds or sinusitis	☐	☐
11. Tuberculosis or lung problems	☐	☐
12. Digestive problems	☐	☐
13. Stomach ulcers	☐	☐
14. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	☐	☐
15. Kidney disease	☐	☐
16. Venereal disease (STD)	☐	☐
17. Diabetes	☐	☐
18. Thyroid problems	☐	☐
19. Skin disease	☐	☐
20. Eye problems	☐	☐
21. Arthritis	☐	☐
22. Epilepsy	☐	☐
23. Nervous disorders	☐	☐
24. Frequent headaches	☐	☐
25. Dizzy spells and/or fainting spells	☐	☐
26. Earaches	☐	☐
27. Hayfever	☐	☐
28. Asthma	☐	☐
29. Do you smoke?	☐	☐
30. Have you ever had radiotherapy and/or chemotherapy treatments (tumor)?	☐	☐
31. Do you carry the AIDS virus?	☐	☐
32. Do you have AIDS symptoms?	☐	☐
33. Do you have artificial joints? (knee, hip, etc.)	☐	☐

34. Do you have any of the following allergies? :

	YES	NO		YES	NO
Food	☐	☐	Sulfonamides	☐	☐
Penicilline	☐	☐	Codeine	☐	☐
Aspirin	☐	☐	Local anaesthesia	☐	☐
Iodine	☐	☐	Other _____	☐	☐

35. Were you ever hospitalized or have you undergone surgery other than dental? If so, indicate which ones and when?

_____

_____

_____

	YES	NO
36. Is there anything concerning your health that you wish to discuss privately with your dentist?	☐	☐

Remarks: _____

_____

_____

FOR PHYSICIAN USE ONLY:

MEDICAL ALERT!

DENTAL HISTORY

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

Treatments received _____

Did you previously have dental treatments such as? :

	YES	NO
1. Oral hygiene instruction	☐	☐
2. Gum treatment	☐	☐
3. Orthodontic treatment	☐	☐
4. Root canal treatment	☐	☐
5. Dental fillings	☐	☐
6. Crown and/or bridge	☐	☐
7. Partial and/or complete denture	☐	☐
8. Surgical treatment or extraction	☐	☐
9. Dental implants	☐	☐
10. X-Rays	☐	☐
11. Other _____	☐	☐

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 authorize the setting up of my dental file, its follow-up, as well as 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 his/her (their) auxiliary personnel will have access to it.

Signature _____
Patient or Guardian

Date ___ / ___ / ___
Day Month Year

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 _____
Attending Dentist

Date ___ / ___ / ___
Day Month Year