

## 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

<p>3. Are you presently taking natural or homeopathic products? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Specify _____</p> <p>Birth control pills? <input type="checkbox"/> <input type="checkbox"/></p> <p>Hormones? Specify _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Did you recently experience a significant weight loss or gain? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Are you pregnant? <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you breastfeeding? <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Are you suffering or have you ever suffered from :</b></p> <p>6. Heart disease (stroke, angina, valvular problems, murmur) <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Rheumatic fever <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Blood problems :</p> <p>8.1 Hemophilia <input type="checkbox"/> <input type="checkbox"/></p> <p>8.2 Prolonged bleeding <input type="checkbox"/> <input type="checkbox"/></p> <p>8.3 Clear blood <input type="checkbox"/> <input type="checkbox"/></p> <p>8.4 Anemia <input type="checkbox"/> <input type="checkbox"/></p> <p>8.5 Others, specify _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Blood pressure High <input type="checkbox"/> Low <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Frequent colds or sinusitis <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Tuberculosis or lung problems <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Digestive problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Specify _____</p> <p>13. Stomach ulcer <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Liver disease (hepatitis A, B, C, cirrhosis, etc.) <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Kidney problems <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Do you urinate often? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Venereal disease (V.D.) <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Diabetes <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Thyroid problems <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Skin disease <input type="checkbox"/> <input type="checkbox"/></p>	<p>21. Eye problems <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Arthritis <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Osteoporosis <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you take bisphosphonates? <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Epilepsy <input type="checkbox"/> <input type="checkbox"/></p> <p>25. Nervous disorders <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Mental illness <input type="checkbox"/> <input type="checkbox"/></p> <p>Specify _____</p> <p>27. Frequent headaches <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Dizzy spells or fainting spells <input type="checkbox"/> <input type="checkbox"/></p> <p>29. Earaches <input type="checkbox"/> <input type="checkbox"/></p> <p>30. Hay fever <input type="checkbox"/> <input type="checkbox"/></p> <p>31. Asthma <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Do you smoke? <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor)? <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Do you have AIDS symptoms? <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Are you an AIDS virus carrier? <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Do you have artificial joints (knee, hip, etc.)? <input type="checkbox"/> <input type="checkbox"/></p> <p>37. Do you snore or have you ever been told that you snore? <input type="checkbox"/> <input type="checkbox"/></p> <p>38. Do you have any of the following allergies:</p> <p>38.1 Latex <input type="checkbox"/> <input type="checkbox"/></p> <p>38.2 Food <input type="checkbox"/> <input type="checkbox"/></p> <p>38.3 Iodine <input type="checkbox"/> <input type="checkbox"/></p> <p>38.4 Aspirin <input type="checkbox"/> <input type="checkbox"/></p> <p>38.5 Sulfonamides <input type="checkbox"/> <input type="checkbox"/></p> <p>38.6 Penicillin <input type="checkbox"/> <input type="checkbox"/></p> <p>38.7 Codeine <input type="checkbox"/> <input type="checkbox"/></p> <p>38.8 Other antibiotics <input type="checkbox"/> <input type="checkbox"/></p> <p>38.9 Local anaesthesia <input type="checkbox"/> <input type="checkbox"/></p> <p>38.10 Others <input type="checkbox"/> <input type="checkbox"/></p> <p>Specify _____</p> <p>39. Do you use drugs? <input type="checkbox"/> <input type="checkbox"/></p>
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## CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

### Medical history (continued)

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 \_\_\_\_\_

Yes No

42. Do you fear dental treatments ?  
 Not at all  A little  A lot
43. Is there anything concerning your health you wish to discuss privately with your dentist ?    
 Remarks \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Yes No

### 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 | <input type="checkbox"/> | <input type="checkbox"/> | 7. Partial or/and complete denture  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Gum treatment             | <input type="checkbox"/> | <input type="checkbox"/> | 8. Surgical treatment or extraction | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Orthodontic treatment     | <input type="checkbox"/> | <input type="checkbox"/> | 9. Dental implants                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Root canal treatment      | <input type="checkbox"/> | <input type="checkbox"/> | 10. X-rays                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Dental fillings           | <input type="checkbox"/> | <input type="checkbox"/> | 11. Others                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Crown or/and bridge       | <input type="checkbox"/> | <input type="checkbox"/> |                                     |                          |                          |

### 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 \_\_\_\_\_