CLINIQUE DENTAIRE TREMBLAY

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# CONFIDENTIAL QUESTIONNAIRE

**Patient File #:**

Patient Name: _____ First name: _____ F ☐ M ☐ Date of birth: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Tel #: Home _____ Work : _____ Cellular : _____

Married ☐ Single ☐ Weight: _____ Height: _____ Language spoken: French ☐ English ☐ Other ☐

Medicare card #: _____ Expiry date: _____ Dental insurance: yes ☐ no ☐

Name of employer: _____ Occupation: _____

Reason for your visit: _____

Name of dentist/and their specialty: _____ Referred by: _____

Most recent dental visit: _____ Purpose: _____

What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

## MEDICAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Are you presently under a doctor's care? | | |
| 2. Women/Are you pregnant? | | |
| 3. Women/Are you taking any birth control? | | |
| 4. Male/Prostate disorders | | |
| 5. Heart problems | | |
| 6. Episodes of prolonged bleeding | | |
| 7. Anemia or other blood disorder | | |
| 8. Blood pressure (high ☐ low ☐) | | |
| 9. Rheumatic fever | | |
| 10. Frequent colds or sinus problems | | |
| 11. Tuberculosis or pulmonary problems | | |
| 12. Asthma | | |
| 13. Hay fever | | |
| 14. Digestive disorders | | |
| 15. Stomach or duodenal ulcer | | |
| 16. Liver disease | | |
| 17. Diabetes | | |
| 18. Thyroid or parathyroid disease | | |
| 19. Arthritis | | |
| 20. Skin disease, rashes | | |
| 21. Glaucoma, other eye problem | | |
| 22. Epilepsy, convulsions (seizures) | | |
| 23. Frequent headaches | | |
| 24. Dizziness, fainting | | |
| 25. Earaches | | |
| 26. Nervous disorder, depression | | |
| 27. Have you ever received chemotherapy or radiation therapy? | | |
| 28. Alcohol/drug dependency | | |
| 29. Do you have Human immunodeficiency virus (HIV/AIDS)? | | |
| 30. Do you have artificial prosthesis (heart valve or joints)? | | |
| 31. Do you have any allergic reactions to? | | |
| Certain Foods | | |
| Tetracycline | | |
| Iodine | | |
| Codeine | | |
| Aspirine | | |
| Local anesthetic | | |
| Penicillin | | |
| Metals | | |
| Latex | | |
| Erythromycine | | |
| Sulfamide | | |
| Any other medication | | |
| 32. Are you taking medication for osteoporosis/osteopenia? | | |

## DENTAL HISTORY

| Have you ever received dental treatments such as? | YES | NO |
|---|---|---|
| 1. Dental hygiene demonstration | | |
| 2. Gum treatments | | |
| 3. Orthodontic treatments | | |
| 4. Root canal | | |
| 5. Fillings | | |
| 6. Crowns or bridges | | |
| 7. Complete or artificial denture | | |
| 8. Extraction | | |
| 9. Dental implants | | |
| 10. Dental radiology | | |
| 11. Other, please specify: | | |

For dentist use only.

List of medication/supplements and/or vitamins taken in the last 2 years:

| Medication | Reason | Medication | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING**

I declare having read, understood, having informed myself and having answered the above confidential dental-medical questionnaire to the best of my knowledge. I commit to informing you immediately of any change in my medical status.

Patient's signature _____ Date _____

Doctor's signature _____ Date _____