CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

(The following information is requested to enable us to give you the most consideration of your time and feelings)

PERSONAL INFORMATION

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

Address: ______________ City: ______________ Postal Code: ______________

Tel: Res.: ______________ Work: ______________ Ext.: ______________ Cell: ______________

E-mail: ______________

Married: Yes ☐ No ☐ (other): ______________ Height: ______________ Weight: ______________ Date of birth: ______________

Occupation: ______________ Employer: ______________

Medicare number: ______________ Guardian: ______________

Referred by: ______________

Motive for visit: ______________

MEDICAL HISTORY

1. Are you presently under a doctor's care? If yes:
Last Name: ______________ First Name: ______________
Tel.: ______________ Ext.: ______________

	YES	NO
2. Are you presently taking any drug or medication, or have you taken any in the last 6 months?	☐	☐
If so, 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, valvular problems, and murmur)	☐	☐
6. Rheumatic fever	☐	☐
7. Prolonged bleeding	☐	☐
8. Anemia	☐	☐
9. Blood pressure: High ☐ Low ☐	☐	☐
10. Frequent cold or sinusitis	☐	☐
11. Tuberculosis or lung problems	☐	☐
12. Digestive problems	☐	☐
13. Stomach ulcer	☐	☐
14. Liver disease (hepatitis A, B, C, cirrhoses, etc.)	☐	☐
15. Kidney disease	☐	☐
16. Venereal disease (VD)	☐	☐
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 fainting spells	☐	☐

	YES	NO
26. Earaches	☐	☐
27. Hay fever	☐	☐
28. Asthma	☐	☐
29. Do you smoke?	☐	☐
30. Have you ever had radiotherapy and/or chemotherapy (tumor)?	☐	☐
31. Do you have AIDS symptoms?	☐	☐
32. Are you an AIDS virus carrier?	☐	☐
33. Do you have artificial joints (knee, hip, etc.)?	☐	☐

34. Do you have any of the following allergies?

Food	_____	Sulfamides	_____
Penicillin	_____	Codeine	_____
Aspirin	_____	Local anesthesia	_____
Iodine	_____	Others	______________

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

____
____
____

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

For the dentist's use:

Pre-operatory precautions ______________
____
____
Remarks ______________
____

DENTAL HISTORY

Date of the last dental visit ______________ Treatment received ______________

	YES	NO
1. Does your jaw click or hurt?	☐	☐
2. Do you feel you grind your teeth?	☐	☐
3. Have you ever had orthodontic treatment?	☐	☐
4. Do you wear a night guard?	☐	☐
5. Have you ever had gum disease?	☐	☐
6. Do you bite your lips or cheek often?	☐	☐

	YES	NO
7. Do you think you have occasional bad breath?	☐	☐
8. Do your gums ever bleed when you brush your teeth?	☐	☐
9. Do you experience sensitivity with hot/cold?	☐	☐
10. Does floss ever tear between your teeth?	☐	☐
11. Does food get jammed between your teeth?	☐	☐
12. Do your teeth ever hurt when you bite hard?	☐	☐

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, the follow-up, as well as my registration on the recall list(s) of the treating dentist(s).

Signature ______________
Patient or guardian

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.

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