CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

CENTRE DE SANTÉ DENTAIRE DE BROMONT

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his staff have access to it. Patients are also entitled to access their file and make corrections.

Personal Information and Contact Information

First name : _____ Home tel. : _____

Last name : _____ Work tel. : _____

Sex : ◯ Female ◯ Male ◯ Other Cell phone : _____

Date of birth (YYYY-MM-DD) : _____ E-mail : _____

Health Ins. No : _____ Referred by : _____

Address : _____ City : _____

Province : _____ Postal code : _____

Dental Information

Reason for today's visit : _____ Do you fear dental treatments ?

Last visit : ◯ 0 – 6 months ◯ 6 – 12 months ◯ + than 12 months ◯ Not at all ◯ A little ◯ Very much

Treatment(s) received: _____ Specify : _____

Medical history	Yes	No	Reason, details and date
1. Are you being treated by a doctor ?	☐	☐	
2. Have you ever had surgery or been hospitalized ?	☐	☐	
3. Do you have joint prostheses (hip, knee, etc.) ?	☐	☐	
4. Have you gained or lost a lot of weight recently ?	☐	☐	
5. Are you pregnant ?	☐	☐	
6. Are you breastfeeding ?	☐	☐	

Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months

Medications and natural products	Reasons

Consent to communicate with my pharmacy :

Name: _____ Phone : _____

I consent to the dentist and his staff collecting relevant information consistent with the subject of the file from the pharmacy mentioned above or communicating such information to them.

_____ _____

Signature of the patient or designated representative Date

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications.
It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

	Yes	No
Blood disorders		
(hemophilia, anemia, prolonged bleeding)	☐	☐
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	☐	☐
Heart infection (endocarditis)	☐	☐
Valve surgery	☐	☐
Blood pressure : ◯ High ◯ Low	☐	☐
Controlled	☐	☐
Dizziness, fainting	☐	☐
Frequent headaches	☐	☐
Jaw pain	☐	☐
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	☐	☐
Digestive system diseases	☐	☐
Skin diseases	☐	☐
Stomach disorders : ☐ ulcer ☐ reflux	☐	☐
Diabetes: ◯ Type 1 ◯ Type 2	☐	☐
Controlled	☐	☐
Thyroid disorders	☐	☐
Controlled	☐	☐
Cancer/Tumor	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Sexually transmitted or blood-borne infections (STBBI)	☐	☐

	Yes	No
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention / treatment (e.g.: tablets, injections)	☐	☐
Annual or monthly injection	☐	☐
Kidney disorders	☐	☐
Chronic pain	☐	☐
Epilepsy	☐	☐
Nervous system disorders or diseases	☐	☐
Mental disorders or illnesses	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis or lung disorders	☐	☐
Asthma	☐	☐
Hay fever / seasonal allergies	☐	☐
Dry mouth	☐	☐

Allergy or manifestation with products containing :

Latex	☐	☐	Sulfonamides	☐	☐
Penicillin	☐	☐	Anesthetic	☐	☐
Other antibiotics	☐	☐	Aspirin	☐	☐
Codeine	☐	☐	Other :		☐ ☐

Other medical conditions that should be mentioned :

If yes of one above, please specify:

ex : date, type, other

Do you smoke ? Ex-smoker : ☐ ..... Stop date: ☐ ☐

For how many years have you smoked?

Number of cigarettes per day?

Do you drink alcohol ? ☐ ☐

Frequency : drinks ◯ day ◯ week ◯ month

Do you snore ? ☐ ☐

Do you suffer from sleep apnea ? ☐ ☐

Do you use drugs, including cannabis ? ☐ ☐

Quantity per day :

Do you take methadone? ☐ ☐

For emergencies, call:

Name : Main tel. :

Consent and identification

I have filled out this medical-dental questionnaire to the best of my knowledge.

Signature of the patient or designated representative

Date

◯ Patient him / herself

◯ Parent / guardian (if under 14 yrs. old)

◯ Legal / authorized representa

◯ Mr. ◯ Ms.