DENTAL FILE
Confidential Questionnaire of Introduction

Tél. : (514) 620-7084 Fax : (514) 620-5202 4999 Boul. St-Charles, suite 101, Ste-Geneviève QC H9H 3M8

Last Name : _____ **First Name :** _____

Address : _____ **Apt :** ____ **City :** _____ **Postal Code :** _____

 # Tel. Res. : _____ **# Office:** _____ **Cell :** _____

Sex : M ☐ F ☐ **Date of Birth:** Day _____ month _____ Year _____

Name of employer : _____ **Occupation** _____

Name of spouse : _____ **E-Mail :** _____

Motive for visit : _____

Who referred you to our clinic : _____

Medicare No. : _____-_____-_____ **Mother :** _____ **Tel. Work :** _____ **Cell :** _____

Expiring date: _____ / _____ **Father :** _____ **Tel. Work :** _____ **Cell :** _____

MEDICAL HISTORY

1) Are you presently under a doctor's care? If YES :
Name :_____
Tel. :_____

	YES	NO
2) Are you presently taking any drugs or medication, Or have you taken any in the last six 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, murmur).....	☐	☐
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 problems.....	☐	☐
14) Liver disease *(hepititis: A,B, C, cirrhosis, etc.)*.....	☐	☐
15) Kidney disease.....	☐	☐
16) Venereal disease (V.D.)	☐	☐
17) Diabetes.....	☐	☐
18) Thyroid problems	☐	☐
19) Skin disease	☐	☐

	YES	NO
20) Eye problems	☐	☐
21) Arthritis.....	☐	☐
22) Epilepsy	☐	☐
23) Nervous disorders	☐	☐
24) Frequent headaches.....	☐	☐
25) Dizzy spells and fainting spells	☐	☐
26) Earaches	☐	☐
27) Hay fever	☐	☐
28) Asthma	☐	☐
29) Do you smoke cigarettes?..... *#/day* :_____ Do you consume cannabis? .....#/day:_____	☐	☐
30) Have you ever had radiotherapy or/and chemotherapy treatments (tumors)?.....	☐	☐
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?

	YES	NO		YES	NO
Food	☐	☐	Sulfonamides	☐	☐
Penicillin	☐	☐	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 :
_____ *Year:* _____
_____ *Year:* _____

	YES	NO
36) Would you preferdiscussing your medical health in private?	☐	☐

RÉSERVÉ AU PERSONNEL DENTAIRE – RÉVISION QUESTIONNAIRE MÉDICAL (DATE)

SEE VERSO

ACDQ Association des chirurgiens dentistes du Québec

Dre. France Gascon D.M.D.
www.drefgascon.ca

Ordre des Dentistes du Québec

Tél.: (514) 620-7084 • Fax: (514) 620-5202 • 4999 boul. St-Charles, suite 101 Ste-Geneviève, QC H9H 3M8

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DENTAL HISTORY

Last visit : ***0 – 6 m*** ☐ ***6 – 12 m*** ☐ ***+ 12 m*** ☐ _____ ***Treatments received :*** _____

Main complaint : _____

_____

Have you previously had dental treatment such as :	***YES***	***NO***
1) Oral hygiene instruction	☐	☐
2) Gum treatment	☐	☐
3) Orthodontic treatment	☐	☐
4) Root canal	☐	☐
5) Dental fillings	☐	☐
6) Crowns or/and bridge.	☐	☐
7) Partial or/and complete denture	☐	☐
8) Surgical treatment or extraction	☐	☐
9) Dental implants	☐	☐
10) Dental x-rays	☐	☐
11) Other : _____	☐	☐

Do you feel you have :	***YES***	***NO***
1) Gum problems (abnormal sensitivities, bleeding gum)	☐	☐
2) Breath problems	☐	☐
3) Discoloring teeth	☐	☐
4) Abnormal wear of your teeth (grinding)	☐	☐
5) Mobile teeth	☐	☐
6) Dental spaces that should be replaced	☐	☐
7) Snoring problems	☐	☐
8) Food often staying between teeth	☐	☐
9) Sensitive teth to cold, heat, sweets, or pressure	☐	☐

Dental habits :

Frequency of your brushing _____/day Frequency of flossing _____/day

Do one or more of the following reasons restrain you from having dental treatment?	***YES***	***NO***
1) Fear of pain	☐	☐
2) Cost of treatment	☐	☐
3) Lack of interest	☐	☐
4) Lack of comprehension about the proposed treatment	☐	☐
5) Lack of time	☐	☐
6) Bad experience	☐	☐

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(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.

I also have 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 : _____
(Patient or guardian)

DATE : _____] _____] _____
Day *Month* *year*

Thank you for your collaboration

I acknowledge that I have read the answers to the above queationnaire and that I have taken customary measures, as the case may be.

SIGNATURE : _____
(Attending Dentist)

DATE : _____] _____] _____
Day *Month* *Year*