CENTRE DENTAIRE
MATTHIEU MÉNARD

CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

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 or her staff have access to it. Patients are also entitled to access their file and make corrections.

Personal Information

First name

Last name

Sex F ☐ M ☐

Date of birth / / JJ / MM / AAAA

Health Ins. No. Expiry

Address

City

Province Postal code

Home tel.

Work tel.

Cell phone

E-mail

For emergencies, call:

Name

Relationship to patient

Main tel.

Cell phone

Referred by

Dental Information

Reason for today's visit

Do you fear dental treatments?

Not at all ☐ A little ☐ Very much ☐

Specify

Last visit 0-6 months ☐ 6-12 months ☐ + than 12 months ☐

Treatment(s) received

	Yes	No
With panoramic radiographs (large x-ray)?	☐	☐
With intraoral radiographs (small x-rays)?	☐	☐

Reason, details and date

Specify

Medical history:

	Yes	No
1. Would you like to speak privately with your dentist?	☐	☐
2. Are you being treated by a physician?	☐	☐
3. Have you ever had surgery or been hospitalized?	☐	☐
4. Do you have joint prostheses (hip, knee, etc.)?	☐	☐
5. Have you gained or lost a lot of weight recently?	☐	☐
6. Are you pregnant?	☐	☐
7. Are you breastfeeding?	☐	☐
8. Are you taking natural or homeopathic products?	☐	☐
9. Are you taking medication?	☐	☐
10. Are you taking birth control ☐ or hormones ☐ ?	☐	☐

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

If you cannot list all your medications, you must provide us with the list issued by your pharmacist.

Medication and reason	
1.	5.
2.	6.
3.	7.
4.	8.

Consent to communicate with a health professional

Family physician, specialist, pharmacist, other

Name	Title	Institution / telephone

I hereby agree to allow the dentist and his or her staff to obtain information that is relevant to or consistent with the purpose of the file from the health professionals listed above or to disclose such information to these health professionals.

Signature of the patient or designated representative

Date

Please check Yes or No for each current or past condition

	Yes	No
Blood disorders (hemophilia, anemia, prolonged bleeding)	☐	☐
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	☐	☐
Specify		
Heart infection (endocarditis)	☐	☐
Surgery to replace or repair a valve /cusp	☐	☐
Blood pressure high ☐ low ☐	☐	☐
Dizziness, fainting	☐	☐
Frequent headaches	☐	☐
Jaw pain	☐	☐
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	☐	☐
Specify		
Digestive system disorders or diseases	☐	☐
Specify		
Stomach disorders ulcer ☐ reflux ☐	☐	☐
Kidney disorders	☐	☐
Diabetes	☐	☐
Thyroid disorders	☐	☐
Cancer (tumour) Specify	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Do you suffer from dry mouth?	☐	☐
Sexually transmitted or blood-borne infections (STBBI)	☐	☐
Specify		
Skin diseases	☐	☐
Eye disorders - excluding myopia and presbyopia	☐	☐
Glaucoma	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention / treatment (e.g.: tablets)	☐	☐
Annual or monthly injection	☐	☐

	Yes	No
Chronic pain	☐	☐
ADD / ADHD	☐	☐
Autism / PDD	☐	☐
Epilepsy	☐	☐
Nervous system disorders or diseases	☐	☐
Mental disorders or illnesses	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis or lung disorders	☐	☐
Asthma	☐	☐
Hay fever / seasonal allergies	☐	☐
Allergy or manifestation with products containing:		
Latex	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Sulfonamides	☐	☐
Anesthésiques	☐	☐
Iodine-containing products	☐	☐
Food	☐	☐

Other:

Other medical conditions that should be mentioned:

Other aspects

	Yes	No
Do you snore?	☐	☐
Do you suffer from sleep apnea?	☐	☐
Do you use a cepap?	☐	☐
Do you smoke? (tobacco or cannabis).....ex-smoker	☐	☐
Frequency : cig./day		
Do you drink alcohol?	☐	☐
Frequency: drinks ☐ /day ☐ /week ☐ /month		
Do you take drugs?	☐	☐
Specify		
Do you take methadone?	☐	☐

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.

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

Mr. ☐ Ms. ☐

Name in print

Patient him/herself ☐
Parent/guardian (if under 14 yrs. old) ☐
Legal/authorized representative ☐
Other ☐

I have reviewed the medical-dental questionnaire and indicated all changes.

Signature _____ Date _____ Signature _____ Date _____

Operative precautions–For use by the professional

_____ _____

Signature du dentiste — Date