ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

Ordre des dentistes du Québec

# CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

The information contained in the medical-dental questionnaire is necessary for the provision of dental care. Your dental record is protected by law and professional secrecy. It is kept in the office and only the dentist and authorized personnel may consult it and make entries.

## Personal Information

First name _____

Last name _____

Gender F ○ M ○ X ○

Date of birth _____ YY/MM/DD

Health Ins. No. _____ Expiry YY/MM

Address _____

City _____

Province _____ Postal code _____

## Contact Information

Home tel. _____

Work tel. _____

Cell phone _____

E-mail _____

For emergencies, call:

Name _____

Relationship to patient _____

Main tel. _____

Cell phone _____

## 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) | ○ | ○ |

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.

## Operative precautions–For use by the professional

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

## 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 ○? | ○ | ○ |

**Reason, details and date**

_____

_____

_____

_____

Specify _____

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

| Medication and reason | Medication and reason |
|---|---|
| | |
| | |
| | |
| | |

**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. | ○ | ○ |
| 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.) | ○ | ○ |
| 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 _____ | | |

| | Yes | No |
|---|---|---|
| Skin diseases | ○ | ○ |
| Eye disorders | ○ | ○ |
| Earaches | ○ | ○ |
| Arthritis | ○ | ○ |
| Osteoporosis | ○ | ○ |
| Prevention / treatment (e.g.: tablets) | ○ | ○ |
| Annual or monthly injection | ○ | ○ |
| 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 | ○ | ○ |
| Allergy or manifestation with products containing: | | |
| Latex ○ ○ | | |
| Penicillin ○ ○ | | |
| Other antibiotics ○ ○ | | |
| Codeine ○ ○ | | |
| Aspirin ○ ○ | | |
| Sulfonamides | ○ | ○ |
| Anesthetic | ○ | ○ |
| Food | ○ | ○ |
| Iodine-containing products | ○ | ○ |
| Other: _____ | ○ | ○ |

Other medical conditions that should be mentioned:

_____

**Other aspects**

| | | |
|---|---|---|
| Have you ever been told that you snore or seem to stop breathing while you sleep? | ○ | ○ |
| Do you wake up tired in the morning and/or feel tired during the day? | ○ | ○ |
| Do you suffer from sleep apnea? | ○ | ○ |
| Do you smoke? ____ cig./day or ex-smoker ○ | ○ | ○ |
| Do you drink alcohol? | ○ | ○ |
| Frequency: ____ drinks ○ /day ○ /week ○ /month | ○ | ○ |
| Do you use cannabis? | ○ | ○ |
| Do you take other drugs? | ○ | ○ |
| Do you take methadone? | ○ | ○ |

**Section reserved for the dentist's special notes**

## Consent and identification

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

YY/MM/DD

Patient or authorized person's signature* Date

Name in print

*If the patient is a minor under 14 years of age: the holder of parental authority (including the parent) or the guardian. If the patient is a minor aged 14 or over: the minor, the holder of parental authority (including the parent) or the guardian.

**I have reviewed the medical-dental questionnaire and reported any changes in my health since the previous visit.**

YY/MM/DD

Signature Date

Signature Date

YY/MM/DD

Signature Date

Signature Date

YY/MM/DD

Signature Date

Signature Date

YY/MM/DD

Signature Date

Signature Date



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