Centre dentaire
Patricia Skaf

Reserved for the dental professional / Special

CONFIDENTIAL QUESTIONNAIRE

Surname______________________ Name______________________ Sex : ☐ M ☐ F

Address:____
No. St. Apt. City Postal code

Telephone: Home__________________ Office__________________ Cell:__________________

Date of birth: Year ________Month________Day________ E-mail:__________________

Medicare No.:______________________ Exp. date:______________________

If under 18, write the name of the parent or guardian: ☐ M. ☐ Mrs ______________________

Emergency contact:______________________ Reason for visit:______________________

If this a referral, please write the person's name? Name:______________________

How did you find us? ☐ Local paper ☐ Yellow pages ☐ Internet ☐ Passing ☐ by Other ____________

MEDICAL HISTORY

	Yes	No
1. Are you presently under the care of a doctor?	☐	☐
If so, why? ______________________		
Doctor's name ______________________		
Telephone:______________________		
2. Have you taken prescribed medication in the past 6 months (now or in the past)?	☐	☐
If so, please specify ______________________		
3. Are you presently using natural or homeopathic products?		
• If so, please specify______________________	☐	☐
• Are you using an oral contraceptive?	☐	☐
4. Have you recently lost or gained a lot of weight?	☐	☐
5. Are you pregnant?	☐	☐
• Are you breast-feeding?	☐	☐

Have you ever suffered from any of the following (now or in the past)?

	Yes	No
6. Heart Disease:		
• Chest pain	☐	☐
• Blood pressure ☐ High ☐ Low	☐	☐
• Heart murmur	☐	☐
• Valvular problem	☐	☐
• Rheumatic fever	☐	☐
• Pacemaker	☐	☐
• Artificial valve	☐	☐
• Coronary; angina	☐	☐
7. Blood Problems:		
• Haemophilia	☐	☐
• Prolonged bleeding	☐	☐
• Thin blood	☐	☐
• Anaemia	☐	☐
• Latent or full-blown AIDS	☐	☐
• Have you been prescribed a blood-thinner ? (aspirine, Coumadin, etc.)	☐	☐
• Other, specify______________________		
8. Respiratory Problems:		
• Frequent colds or sinusitis	☐	☐
• Tuberculosis or lung problems	☐	☐
• Asthma	☐	☐
9. Joint/Bone Problems:		
• Arthritis	☐	☐
• Back or neck aches	☐	☐
• Artificial joints	☐	☐
• Osteoporosis	☐	☐
• Have you been prescribed a biophosphonate (now or in the past)?	☐	☐

	Yes	No
10. Nervous Disorders:		
• Fainting spells; dizziness	☐	☐
• Frequent headaches	☐	☐
• Epilepsy	☐	☐
• Psychiatric problems	☐	☐
specify:______________________		
11. Diabetes-Related Problems:		
• Urinating more than 6 times a day	☐	☐
• Dry mouth	☐	☐
• Special diet	☐	☐
• Insulin	☐	☐
• Coma	☐	☐
• Pancreas transplant	☐	☐
12. Thyroid Problems: ☐ Hyperthyroidism ☐ Hypothyroidism		
13. Other Health Problems:		
• Cancer (chemotherapy; radiotherapy)	☐	☐
• Liver problem (cirrhosis, jaundice, etc.)	☐	☐
• Hepatitis A ☐ B ☐ C ☐		
• Digestive problem, specify______________	☐	☐
• Stomach ulcer	☐	☐
• Kidney disease	☐	☐
• Venereal disease (STD)	☐	☐
• Skin disease	☐	☐
• Eye problem (glaucoma)	☐	☐
• Earache	☐	☐
• Venereal disease (herpes, etc.)	☐	☐
• Hay fever	☐	☐
• Do you smoke?	☐	☐
• Do you take hallucinogenic drugs?	☐	☐
• Do you drink alcoholic beverages?	☐	☐
☐ A little ☐ Moderately ☐ A lot		
• Do you snore or have you been told that you snore?	☐	☐

14. Are you intolerant or allergic to any of the following?

	Yes	No		Yes	No
• Latex	☐	☐	• Penicillin	☐	☐
• Some foods	☐	☐	• Codeine	☐	☐
• Iodine	☐	☐	• Other antibiotics	☐	☐
• Aspirine	☐	☐	• Local anaesthesia	☐	☐
• Barbiturates	☐	☐	• Sulphonamides (sulpha drugs)	☐	☐

• Other, specify______________________

	Yes	No
15. Have you ever been hospitalised or operated on for non-dental problems?	☐	☐

If so, please specify the intervention and date:

______________________ date________
______________________ date________
______________________ date________

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