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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, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

FIRST NAME:	LAST NAME:			F	M
E-MAIL:			DATE OF BIRTH:		
ADDRESS:				(DD/MM/Y	YYY)
CITY:	PROVI	NCE:	POSTAL CODE:		
HOME PHONE:	WORK PHO	ONE:	CELL PHONE:		
For emergencies, call:					
NAME:		RELAT	TIONSHIP TO PATIENT:		
MAIN PHONE:		CELL	PHONE:		
Dental information:					
Reason for today's visit. Are you looking for	a specific solut	ion?			
Name of your general dentist: Dr					
Names of dental specialists you have consu	•		_		
Dr	Dr		Dr		
This questionnaire will help the dentist and tions. It is in the patient's best interest to ca					complic
tions. It is in the patients best interest to da	cratty mere out	and notiny tine	dentise of any change in their neather	condition.	
	Yes N	0			
Medical history	IES IN	•		Yes	No
•			breastfeeding?	Yes	No
Are you being treated by a physician? Have you ever had surgery or been		Are you	taking natural or homeopathic	Yes	No
Are you being treated by a physician? Have you ever had surgery or been nospitalized? Do you have joint prostheses		Are you Are you product Are you	taking natural or homeopathic s? taking medication?	Yes	No
Are you being treated by a physician? Have you ever had surgery or been nospitalized? Do you have joint prostheses hip, knee, etc.)?		Are you Are you product Are you Are you	taking natural or homeopathic s? taking medication? taking birth control or	Yes	No
Are you being treated by a physician? Have you ever had surgery or been nospitalized? Do you have joint prostheses hip, knee, etc.)? Have you gained or lost		Are you Are you product Are you Are you hormon	taking natural or homeopathic s? taking medication? taking birth control or es?	Yes	No
Medical history Are you being treated by a physician? Have you ever had surgery or been hospitalized? Do you have joint prostheses (hip, knee, etc.)? Have you gained or lost a lot of weight recently? Are you pregnant?		Are you Are you product Are you Are you hormon	taking natural or homeopathic s? taking medication? taking birth control or	Yes	No
Are you being treated by a physician? Have you ever had surgery or been hospitalized? Do you have joint prostheses (hip, knee, etc.)? Have you gained or lost a lot of weight recently?		Are you Are you product Are you Are you hormon	taking natural or homeopathic s? taking medication? taking birth control or es?	Yes	No
Are you being treated by a physician? Have you ever had surgery or been hospitalized? Do you have joint prostheses (hip, knee, etc.)? Have you gained or lost a lot of weight recently? Are you pregnant? Please indicate all medication (includi		Are you Are you product Are you Are you hormon	taking natural or homeopathic s? taking medication? taking birth control or es? I, DETAILS AND DATE:		
Are you being treated by a physician? Have you ever had surgery or been hospitalized? Do you have joint prostheses (hip, knee, etc.)? Have you gained or lost a lot of weight recently?	ng birth conti	Are you Are you product Are you Are you hormon	taking natural or homeopathic s? taking medication? taking birth control or es? I, DETAILS AND DATE:		

Please check Yes or No for each current	or past	condition		Yes	No
	Yes	No	Osteoporosis		
Blood disorders (hemophilia, anemia,			Prevention / treatment (e.g.: tablets)		
prolonged bleeding)			Annual or monthly injection		
Heart conditions			Chronic pain		
Infarction (heart attack), angina, surgery, etc	:. 🔲		Epilepsy		
Heart infection (endocarditis)			Nervous system disorders or diseases		Ц
Surgery to replace or repair a valve/cusp			Mental disorders or illnesses		Ц
Blood pressure			Frequent colds or sinusitis		Ц
high low			Tuberculosis or lung disorders		
Dizziness, fainting			Asthma		
requent headaches			Hay fever / seasonal allergies		
aw pain			Allergy or manifestation with products		
iver disorders (hepatitis A, B, C. cirrhosis, etc.)			containing:		
Digestive system disorders or diseases Specify:			Latex		
tomach disorders ulcer reflux			Sulfonamides		
			Penicillin		
idney disorders			Other antibiotics		
iabetes byroid disordors			Anesthetic		
hyroid disorders ancer (tumour)			Food		
Specify:			Codeine		
adiotherapy			lodine-containing products		
hemotherapy			Aspirin		
nemotherapy to you suffer from dry mouth?			Other		
exually transmitted or blood-borne infection:			Other medical conditions that should b	oe	
STBBI)	· 🗀		mentioned:	_	
Specify:			Other aspects		
kin diseases			Other aspects		
ye disorders			Do you suffer from sleep apnea?		
araches			Do you smoke? Cig./Day		
Arthritis			Do you take drugs? Specify:		
Have you ever had? Yes No			Yes No	Ye	s No
		n treatment	Dental implants	Ye	s No
Crowns or fixed bridges		n treatment or maxillofacial surg	Dental implants	nt _	No No
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