CLINIQUE DE
PROSTHODONTIE
DU WEST-ISLAND

MEDICAL QUESTIONNAIRE

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.

Personal information and contact details

FIRST NAME: _____ LAST NAME: _____ SEX: ☐ F ☐ M

E-MAIL: _____ DATE OF BIRTH: _____ (DD/MM/YYYY)

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

For emergencies, call:

NAME: _____ RELATIONSHIP TO PATIENT: _____

MAIN PHONE: _____ CELL PHONE: _____

Dental information:

Reason for today's visit. Are you looking for a specific solution?

_____

_____

Name of your general dentist: Dr _____

Names of dental specialists you have consulted in the past:

Dr _____ Dr _____ Dr _____

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.

Medical history	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?	☐	☐
Are you breastfeeding?	☐	☐
Are you taking natural or homeopathic products?	☐	☐
Are you taking medication?	☐	☐
Are you taking birth control or hormones?	☐	☐

REASON, DETAILS AND DATE: _____

_____

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

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: _____	☐	☐
Skin diseases	☐	☐
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐

	Yes	No
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	☐	☐
Sulfonamides	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Anesthetic	☐	☐
Food	☐	☐
Codeine	☐	☐
Iodine-containing products	☐	☐
Aspirin _____	☐	☐
Other	☐	☐
Other medical conditions that should be mentioned: _____	☐	☐

Other aspects

	Yes	No
Do you suffer from sleep apnea?	☐	☐
Do you smoke? _____ Cig./Day	☐	☐
Do you take drugs? Specify: _____	☐	☐

Have you ever had?

	Yes	No
Crowns or fixed bridges	☐	☐
Removable dental prosthesis (dentures, partials)	☐	☐
Gum treatment	☐	☐
Oral or maxillofacial surgery	☐	☐
Dental implants	☐	☐
Orthodontic treatment	☐	☐
Endodontic treatment	☐	☐

Family doctor, specialist doctor, pharmacist, other

Name: _____ Fonction: _____ Establishment/telephone: _____

Name: _____ Fonction: _____ Establishment/telephone: _____

Name: _____ Fonction: _____ Establishment/telephone: _____

What could we do to make your visit in our office as pleasant as possible?

_____

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

_____

Signature of the patient or designated representative — Date (DD-MM-YYYY)

_____

Name in print

Operating precautions – For professional use

I have revised the medical-dental questionnaire and informed of all changes.

Sig.: _____ Date: ____ / ____ / ____ / Init.: _____ Date: ____ / ____ / ____ /

Sig.: _____ Date: ____ / ____ / ____ / Init.: _____ Date: ____ / ____ / ____ /

Sig.: _____ Date: ____ / ____ / ____ / Init.: _____ Date: ____ / ____ / ____ /