

Sex: M ☐ F ☐ Last Name: _____ First Name: _____
Address: no. _____ Street: _____ Apt.: _____ City: _____
Postal Code: _____ Tel. Res.: _____ Work: _____ (Ext.): _____ E-mail address: _____
Birthdate: _____ Year: _____ Month: _____ Day: _____ Guardian: _____
Medicare no.: _____ Expiry Date: _____ Social Insurance no. (optional): _____
Referred by: _____ Motive for visit: _____

MEDICAL HISTORY

- Weight _____ Height _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you presently under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes: | | |
| Last Name: _____ First Name: _____ | | |
| Tel.: _____ (Ext.): _____ | | |
| 2. Are you presently taking any drug or medication,
or have you taken any in the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, which: _____ | | |
| 3. Did you recently experience a significant weight loss or gain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you taking any birth control pill? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you suffering or have you ever suffered from: | | |
| 6. Heart disease (stroke, angina, valvular problems, murmur) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Prolonged bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. High <input type="checkbox"/> Low <input type="checkbox"/> Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Frequent colds or sinusitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Tuberculosis or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Digestive problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Stomach ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Liver disease (hepatitis A, B, C, cirrhosis, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Venereal Disease (V.D.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Skin disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Eye problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Dizzy spells or fainting spells | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 27. Earaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had radiotherapy or/and
chemotherapy treatments (tumor)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you have AIDS symptoms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Are you an AIDS virus carrier? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have artificial joints (knee, hip, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have any of the following allergies? | | |

- | | Yes | No | Yes | No |
|-------------------|--------------------------|--------------------------|-------------------|--------------------------|
| Food | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Sulfonamides | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> |
| Other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Local anaesthesia | <input type="checkbox"/> |
| Specify: _____ | | | Others _____ | |

36. Were you ever hospitalized or have you
undergone surgery other than dental?
- If so, indicate which one and when:

_____ Date _____
_____ Date _____
_____ Date _____

37. Is there anything concerning your health you wish
to discuss privately with your dentist?
- Remarks: _____

FOR THE PHYSICIAN'S USE ONLY

PRECAUTIONS:

DENTAL HISTORY

- Last visit: 0-6 months ☐ 6-12 months ☐ 12 months + ☐
- Treatments received: _____
- Have you previously had dental treatments such as: _____
- | | Yes | No |
|------------------------------|--------------------------|--------------------------|
| 1. Oral hygiene instructions | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Gum treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Orthodontic treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Root canal treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Dental fillings | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|-------------------------------------|--------------------------|--------------------------|
| 6. Crown or/and bridge | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Partial or/and complete denture | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Surgical treatment or extraction | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Dental implants | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. X-rays | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Others | <input type="checkbox"/> | <input type="checkbox"/> |

FOR THE PHYSICIAN'S USE ONLY

I acknowledge that I have read the answers to the above questionnaire and that I have
taken the customary measures, as the case may be.

Signature: _____ Date: _____
Attending dentist

Signature: _____ Date: _____
Patient or Guardian