CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M ◉ F ○ Patient Name: Nouveau, _____ Dental Insurance: Yes ○ No ○

Address: _____ City: _____ Company: _____

Postal Code: _____ Tel. Res.: _____ Work: _____ (Ext.): _____ E-mail: _____

I agree to receive appointment confirmations and best dental hygiene tips from Clinique du Boulevard electronically.
I understand I am able to withdraw my consent at any time. ☐

Birthdate: 01/Oct/2016 Guardian: _____

Medicare no.: _____ Expiry Date: _____ Social Insurance no. (optional): _____

For an emergency, contact: _____ Motive for visit: _____

You were Referred By: _____ Employer: _____ Profession: _____

Weight: _____ Height: _____

MEDICAL HISTORY

	Yes	No
1. Are you presently under a doctor's care?	○	○
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?	○	○
If so, which:	○	○
3. Did you recently experience a significant weight loss or gain?	○	○
4. Are you pregnant?	○	○
5. Are you taking any birth control pill?	○	○
Are you suffering or have you ever suffered from:		
6. Heart disease (stroke, angina, valvular problems, murmur)	○	○
7. Rheumatic fever	○	○
8. Prolonged bleeding	○	○
9. Anemia	○	○
10. High ○ Low ○ Blood pressure	○	○
11. Frequent colds or sinusitis	○	○
12. Tuberculosis or lung problems	○	○
13. Digestive problems	○	○
14. Stomach Ulcer	○	○
15. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	○	○
16. Kidney disease	○	○
17. Venereal Disease (STD)	○	○
18. Diabetes	○	○
19. Thyroid problems	○	○
20. Skin disease	○	○
21. Eye problems	○	○
22. Arthritis	○	○
23. Epilepsy	○	○
24. Nervous disorders	○	○
25. Frequent headaches	○	○
26. Dizzy spells or fainting spells	○	○

Are you apprehensive regarding dental treatments:
No ○ A little bit ○ Yes ○ Very ○

Is there one of the following reasons why you're not receiving dental treatments?

Scared of pain ☐ No interest ☐ Availability ☐ Financial issues ☐

Do you like your smile? Yes ○ No ○ What would you like changed:

_____

Do you like your teeth? (colour, form, size)? Yes ○ No ○

	Yes	No
27. Earaches	○	○
28. Hay fever	○	○
29. Asthma	○	○
30. Do you smoke?	○	○
31. Have you ever had radiotherapy and/or chemotherapy treatments (tumor)?	○	○
32. Do you have AIDS symptoms?	○	○
33. Are you an HIV, Hepatitis A,B,C virus carrier?	○	○
34. Do you have artificial joints (knee, hip, etc)?	○	○

35. Do you have any of the following allergies?

	Yes	No		Yes	No
Food	○	○	Iodine	○	○
Aspirin	○	○	Sulfonamides	○	○
Penicillin	○	○	Codeine	○	○
Other antibiotics	○	○	Local anaesthesia	○	○

Specify: _____ Others: _____

36. Were you ever hospitalized or have you undergone surgery other than dental? ○ ○

If so, indicate one and when:

_____ Date: _____

_____ Date: _____

_____ Date: _____

37. Is there anything concerning your health you wish to discuss with your dentist? ○ ○

Remarks:

FOR THE PHYSICIAN'S USE ONLY

PRECAUTIONS:

IMPORTANT

I the undersigned, hereby declare that I have read, understood and answered the above medical-dental questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health. I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of the attending dentist(s). I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

List of medication

Name of medication:	Cause:	Since when: