



Medical Questionnaire

Section to be completed by the **dentist**

Disorders :	_____
Allergy :	yes <input type="radio"/> no <input type="radio"/>
Note :	_____
Doctor :	_____
Tel :	_____

Section to be completed by the **patient**

Date of birth D      M      Y			Provincial health insurance no / Expiration			
Last name			First name			
Adresse			App.	City		
Postal code	Phone - home	Phone - work		Phone - cellular		
Referred by	Person in charge <sup>(If patient is a minor)</sup> Name:		Father <input type="checkbox"/>	Mother <input type="checkbox"/>	Guardian <input type="checkbox"/>	Other <input type="checkbox"/>
Email			Occupation			
Dental insurance yes <input type="radio"/> no <input type="radio"/> company :						
Police Num.	Certificate Num.	Name of insured		Date of birth (of insured)		

Have you suffered or are you suffering from	yes	no
Heart disorders, heart problems (heart attack, angina, breath)	<input type="radio"/>	<input type="radio"/>
Stroke (cardiovascular accident CVA)	<input type="radio"/>	<input type="radio"/>
Cholesterol (hypercholestérolémie)	<input type="radio"/>	<input type="radio"/>
Rhumatic fever	<input type="radio"/>	<input type="radio"/>
Prolonged bleeding	<input type="radio"/>	<input type="radio"/>
Anemia or other blood problems	<input type="radio"/>	<input type="radio"/>
High pressure	<input type="radio"/>	<input type="radio"/>
Low Pressure	<input type="radio"/>	<input type="radio"/>
Frequent colds or sinusitis	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>
Digestive problems (acid reflux)	<input type="radio"/>	<input type="radio"/>
Stomach ulcer or duodenal	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>
Hepatitis (type)	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>
Sexually transmitted diseases (STD)	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Thyroid or parathyroid	<input type="radio"/>	<input type="radio"/>
Skin disease	<input type="radio"/>	<input type="radio"/>
Eye problem (glaucoma)	<input type="radio"/>	<input type="radio"/>

(Please continue with the form on the other side →)

Arthritis	<input type="radio"/>	<input type="radio"/>
Epilepsy or seizures	<input type="radio"/>	<input type="radio"/>
Nervous disorders	<input type="radio"/>	<input type="radio"/>
Frequent headaches	<input type="radio"/>	<input type="radio"/>
Dizziness / fainting	<input type="radio"/>	<input type="radio"/>
Earaches	<input type="radio"/>	<input type="radio"/>
Hay fever (seasonal allergies)	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Radiotherapy	<input type="radio"/>	<input type="radio"/>
HIV-AIDS	<input type="radio"/>	<input type="radio"/>
Joint prosthesis (hip, knee, etc.).	<input type="radio"/>	<input type="radio"/>
Medication antidepressants	<input type="radio"/>	<input type="radio"/>
Alcohol-addiction	<input type="radio"/>	<input type="radio"/>
	<b>Are you</b>	<b>yes    no</b>
Currently under treatment for another disease	<input type="radio"/>	<input type="radio"/>
Smoking	<input type="radio"/>	<input type="radio"/>
Ex-smoker	<input type="radio"/>	<input type="radio"/>
Woman: Do you take birth control pill	<input type="radio"/>	<input type="radio"/>
Woman: Are you pregnant	<input type="radio"/>	<input type="radio"/>
Man: Do you have a prostate disorder	<input type="radio"/>	<input type="radio"/>
	<b>Have you ever had an allergic reaction</b>	<b>yes    no</b>
Aspirin, ibuprofen, acetaminophen	<input type="radio"/>	<input type="radio"/>
Penicillin	<input type="radio"/>	<input type="radio"/>
Iodine	<input type="radio"/>	<input type="radio"/>
Sulfonamides	<input type="radio"/>	<input type="radio"/>
Codeine	<input type="radio"/>	<input type="radio"/>
Local anesthesia	<input type="radio"/>	<input type="radio"/>
Latex	<input type="radio"/>	<input type="radio"/>
Food:	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>

Medication list	Date of revision

Patient	<p>I, undersigned, declare having read, understood, and informed myself and have responded to the best of my knowledge to the medical questionnaire. I hereby take the responsibility to advise you of any change in my health.</p> <p>Patient Signature: _____ date: _____</p> <p>I agree to contact <i>centre dentaire griffin</i> at least <b>48 hours</b> before appointment time if my appointment has to be changed. (This time is reserved for you. Fees of <b>60\$</b> will be applied to your account for non-compliance with this policy.)</p> <p style="text-align: right;">Initiale: _____</p>
Dentist	<p>I have read the medical questionnaire and have taken steps regarding this conditions, if any.</p> <p>Dentist Signature: _____ date: _____</p>