CENTRE DENTAIRE GRIFFIN

Medical Questionnaire

Section to be completed by the **dentist**

Disorders : _____
Allergy : yes ❍ no ❍
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			
Addresse		App.	City		
Postal code	Phone - home	Phone - work	Phone - cellular		
Referred by	Person in charge(If patient is a minor) Name:	Father ❑	Mother ❑	Guardian ❑	Other ❑
Email		Occupation			
Dental insurance yes ❍ no ❍ 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)	❍	❍
Stroke (cardiovascular accident CVA)	❍	❍
Cholesterol (hypercholestérolemia)	❍	❍
Rhumatic fever	❍	❍
Prolonged bleeding	❍	❍
Anemia or other blood problems	❍	❍
High pressure	❍	❍
Low Pressure	❍	❍
Frequent colds or sinusitis	❍	❍
Tuberculosis	❍	❍
Emphysema	❍	❍
Digestive problems (acid reflux)	❍	❍
Stomach ulcer or duodenal	❍	❍
Liver Disease	❍	❍
Hepatitis (type)	❍	❍
Kidney disease	❍	❍
Sexually transmitted diseases (STD)	❍	❍
Diabetes	❍	❍
Thyroid or parathyroid	❍	❍
Skin disease	❍	❍
Eye problem (glaucoma)	❍	❍

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

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

Medication list	Date of revision

Patient

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.

Patient Signature: _____ date: _____

I agree to contact *centre dentaire griffin* at least **48 hours** before appointment time if my appointment has to be changed. (This time is reserved for you. Fees of **60$** will be applied to your account for non-compliance with this policy.)

Initiale: _____

Dentist

I have read the medical questionnaire and have taken steps regarding this conditions, if any.

Dentist Signature: _____ date: _____