ORTHODONTISTE

CONFIDENTIAL HEALTH AND DENTAL QUESTIONNAIRE

First name: ______________________ Last name: ____________________ Gender: ○ F ○ M
Address: ____________________________________ Apt. #: ______ City: ________________
Postal Code: __________ Home Tel.: ____________ Work Tel.: ________________ Ext.: ________
Cell phone: _______________ Email: ____________________
Date of birth (Y/M/D): ____________ Age: ______
Who may we thank for referring you to our office? ________________________________.
Name of your dentist: ____.
Object of the consultation: ____.

DENTAL HISTORY

1. Last dental visit: ○ 0-6 months ○ 6- 12 months ○ more than 12 months
2. Treatment received at that last visit: ____.

MEDICAL HISTORY

1. Are you actually under the care of a physician (or specialist, cardiologist, etc.)? Yes No
   If yes, please provide us with the following information:
   Name of physician: ______________________________.
   Phone: ______________________.
2. Do you take any medication or did you take any during the last 6 months? Yes No
   If yes, please write the name and dosage of the medication(s):
   ____.
3. Have you lost or gained a lot of weight recently? Yes No
4. If you are a woman, are you pregnant? Yes No
5. If you are a woman, do you take contraceptive medication? Yes No

DO YOU HAVE OR HAD THE FOLLOWING MEDICAL CONDITION:

6. Heart related problems (stroke, heart attack, angina, valvular problems, etc.)	Yes	No
7. Rheumatic fever	Yes	No
8. Blood disorders (prolonged bleeding, hemophilia)	Yes	No
9. Anemia	Yes	No
10. Blood pressure: ○ High ○ Low ○ Normal		
11. Frequent colds or sinusitis	Yes	No
12. Tuberculosis or pulmonary disease	Yes	No
13. Digestive disorders	Yes	No
14. Stomach ulcers	Yes	No
15. Liver disorders (hepatitis virus A,B,C, cirrhosis, etc.)	Yes	No
16. Renal disease	Yes	No
17. Sexually transmitted infection (STI)	Yes	No
18. Diabetes	Yes	No
19. Thyroid disorder	Yes	No
20. Skin diseases	Yes	No
21. Eye problems	Yes	No
22. Arthritis	Yes	No
23. Epilepsy	Yes	No
24. Nervous disorders	Yes	No
25. Frequent headaches	Yes	No

26. Dizziness or fainting — Yes No
27. Ear aches — Yes No
28. Hay fever (seasonal allergies) — Yes No
29. Asthma — Yes No
30. Do you smoke? ○ Yes ○ No If yes, how many cigarettes per day? __________ For how many years? ___________
31. Have you ever had radiotherapy and/or chemotherapy for a cancer? — Yes No
    If yes, which type of cancer? ____.
32. Have you been given the diagnosis of AIDS? — Yes No
33. Are you HIV positive? — Yes No
34. Do you have any prosthetic devices (knee or hip)? — Yes No
35. Is it recommended by your physician to take antibiotics before a visit at your dentist? — Yes No
36. Are you allergic or have you had any adverse reaction to the following products:

Latex	○	Food	○	Others	○
Penicillin	○	Iodine	○	Specify: ______________________________	
Aspirin	○	Sulfas	○	______________________________________.	
Codeine	○	Nickel	○		
Local anesthetics	○	Copper and other metals	○		

37. Have you ever been hospitalized and/or had surgery for any health problem other than dental? — Yes No
    If yes, when and explain? ____.

38. Please, inform us of any other medical problem not mentioned above.
    ____.

ORTHODONTIC QUESTIONNAIRE

1. Have you ever suffered from a dental, facial or head trauma/accident? ○ Yes ○ No
   If yes, what kind of trauma: ____.

2. Do you grind your teeth at night? ○ Yes ○ No

3. Do you have pain, clicking or any symptoms to the jaw/joint? ○ Yes ○ No
   If yes, please describe: ____.

4. Have you ever had any previous orthodontic treatment? ○ Yes ○ No
   If yes, when and what kind of treatment: ____.

5. Have you ever sucked your thumb/finger? ○ Yes ○ Yes and still have the habit ○ No

6. Do you have tongue or speech problems? ○ Yes ○ No
   If yes, please describe: ____.

7. Do you breathe through…? ○ The mouth ○ The nose ○ Both

8. Do you bite your nails? ○ Yes ○ No

I, undersigned, certify that I have read, understood, asked the necessary questions and answered this medical and dental questionnaire to the best of my knowledge. I will inform my dentist of any changes affecting my health. I authorize the opening of my record at this office and its follow-up.

____ Date ____________________
Patient signature

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Frederic Lavoie, DMD, MSc, FRCD(C)
Orthodontist