

CONFIDENTIAL HEALTH AND DENTAL QUESTIONNAIRE

If yes, please write the name and dosage of the medication(s): 3. Have you lost or gained a lot of weight recently? 4. If you are a woman, are you pregnant? 5. If you are a woman, do you take contraceptive medication? **Pos No* **DO YOU HAVE OR HAD THE FOLLOWING MEDICAL CONDITION:** 6. Heart related problems (stroke, heart attack, angina, valvular problems, etc.) 7. Rheumatic fever 8. Blood disorders (prolonged bleeding, hemophilia) 9. Anemia 10. Blood pressure: 11. Frequent colds or sinusitis 12. Tuberculosis or pulmonary disease 13. For you are a woman, do you take contraceptive medication? Yes No No No No No Normal	First name:	Last nam	e:		Gender: O F	
Cell phone: Email:	Address:		A	pt. #: City	/:	
Cell phone: Email:	Postal Code: Home Tel.: _		Work Tel.:		Ext.:	
Who may we thank for referring you to our office? Name of your dettist: DENTAL HISTORY 1. Last dental visit: O 0-6 months O 6-12 months O 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.)? 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? If yes, please write the name and dosage of the medication(s): 3. Have you lost or gained a lot of weight recently? 4. If you are a woman, are you pregnant? 5. If you are a woman, do you take contraceptive medication? DO YOU HAVE OR HAD THE FOLLOWING MEDICAL CONDITION: 6. Heart related problems (stroke, heart attack, angina, valvular problems, etc.) 7. Rheumatic fever 8. Blood disorders (prolonged bleeding, hemophilia) 7. Rheumatic fever 9. Anemia 10. Blood pressure: 11. Frequent colds or sinusitis 12. Tuberculosis or pulmonary disease 13. Digestive disorders 7. Yes 14. Stomach ulcers 7. Yes 15. Liver disorders 7. Yes 16. Renal disease 7. Yes 17. Sexually transmitted infection (STI) 7. Yes 18. Dispestive disorders 7. Yes 19. No 19. Skin diseases 7. Yes 10. Skin diseases 7. Yes 10. Skin diseases 7. Yes 10. Sey 11. Eye problems 12. Eye problems 13. Pigestive disorders 14. Stomach ulcers 15. Liver disorders 16. Renal disease 17. Yes 18. No 19. Skin diseases 19. Sey 20. Skin diseases 19. Sey 20. Skin diseases 19. Sey 20. Skip diseases 21. Eye problems 22. Arthritis 23. Eyelproblems 24. Sey 25. Sey 26. Skin diseases 27. Sey 28. No 29. Applied the medication of the medicatio	Cell phone: E	mail:				
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20. Skin diseasesYesNo21. Eye problemsYesNo22. ArthritisYesNo23. EpilepsyYesNo						
21. Eye problemsYesNo22. ArthritisYesNo23. EpilepsyYesNo	•					
22. ArthritisYesNo23. EpilepsyYesNo						
23. Epilepsy Yes No						
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						No

	Dizziness or fainting Ear aches		Yes Yes	No No
	Hay fever (seasonal allergies)		Yes	N
	Asthma		Yes	N
	Do you smoke? O Yes O No If yes, how many cigarettes per day? For how n	anv vear		- •
	Have you ever had radiotherapy and/or chemotherapy for a cancer?	larry year.	Yes	N
01.	If yes, which type of cancer?		105	
32.	Have you been given the diagnosis of AIDS?		Yes	N
	Are you HIV positive?		Yes	N
	Do you have any prosthetic devices (knee or hip)?		Yes	N
	Is it recommended by your physician to take antibiotics before a visit at your dentist?		Yes	N
	Are you allergic or have you had any adverse reaction to the following products:			
	Latex O Food O Others O			
	Penicillin O Iodine O Specify:			
	Aspirin O Sulfas O			
	Codeine O Nickel O			
	Local anesthetics O Copper and other metals O			
	••			
37.	Have you ever been hospitalized and/or had surgery for any health problem other than dental? If yes, when and explain?		Yes	N
38.	Please, inform us of any other medical problem not mentioned above.			
1. H	O Yes	O No		
2. D	If yes, what kind of trauma: Oo you grind your teeth at night?	O Yes	O No	
	o you gima your cooks at ing	2 100	- 1.0	
3. D	O Yes	O No		
4. H	O Yes	O No		
5. H		O No		
6. D	o you have tongue or speech problems? If yes, please describe:	O Yes	O No	
7. D	Oo you breathe through? O The mouth O The nose O Bot	h		
8. D	Oo you bite your nails?	O Yes	O No	
den	ndersigned, certify that I have read, understood, asked the necessary questions and answered to tall questionnaire to the best of my knowledge. I will inform my dentist of any changes affect horize the opening of my record at this office and its follow-up.			
Pat	ient signature			

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