



CONFIDENTIAL HEALTH AND DENTAL QUESTIONNAIRE

First name: Last name: Gender: F M
Address: Apt. #: City:
Postal Code: Home phone: 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:

PARENT(S) INFORMATION

Mother's first name: Mother's last name:
Cell phone: Work tel.: Ext: email:
Father's first name: Father's last name:
Cell phone: Work tel.: Ext: email:

Do you have other children? Yes No If yes, how old are they?

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 | <input type="radio"/> | Food | <input type="radio"/> | Others <input type="radio"/> |
| Penicillin | <input type="radio"/> | Iodine | <input type="radio"/> | Specify: _____ |
| Aspirin | <input type="radio"/> | Sulfas | <input type="radio"/> | _____ |
| Codeine | <input type="radio"/> | Nickel | <input type="radio"/> | |
| Local anesthetics | <input type="radio"/> | Copper and other metals | <input type="radio"/> | |
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.

Patient signature or parent (if under 18 years old)

Date

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