

**Consent to communicate with a health professional**

Family physician, specialist, pharmacist, other

Table with 3 columns: Name, Title, Institution / telephone

I hereby agree to allow the dentist and his or her staff to obtain information that is relevant to or consistent with the purpose of the file from the health professionals listed above or to disclose such information to these health professionals.

Signature of the patient or designated representative \_\_\_\_\_ Date \_\_\_\_\_

**Consent and identification**

I have filled out this medical-dental questionnaire to the best of my knowledge.

Signature of the patient or designated representative \_\_\_\_\_ Date \_\_\_\_\_

Mr.  Ms.  \_\_\_\_\_ Name in print

- Patient him/herself 
Parent/guardian (if under 14 yrs. old) 
Legal/authorized representative 
Other

I have reviewed the medical-dental questionnaire and indicated all changes.

Signature \_\_\_\_\_ Date YY/MM/DD \_\_\_\_\_ Signature \_\_\_\_\_ Date YY/MM/DD
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**CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE**

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

**Personal Information**

First name \_\_\_\_\_
Last name \_\_\_\_\_
Sex F  M 
Date of birth \_\_\_\_\_ YY/MM/DD
Health Ins. No. \_\_\_\_\_ Expiry \_\_\_\_\_ YY/MM
Address \_\_\_\_\_
City \_\_\_\_\_
Province \_\_\_\_\_ Postal code \_\_\_\_\_

**Contact Information**

Home tel. \_\_\_\_\_
Work tel. \_\_\_\_\_
Cell phone \_\_\_\_\_
E-mail \_\_\_\_\_
For emergencies, call:
Name \_\_\_\_\_
Relationship to patient \_\_\_\_\_
Main tel. \_\_\_\_\_
Cell phone \_\_\_\_\_

**Dental Information**

Reason for today's visit \_\_\_\_\_
Do you fear dental treatments?
Not at all  A little  Very much 
Specify \_\_\_\_\_

Last visit 0-6 months  6-12 months  + than 12 months 
Treatment(s) received \_\_\_\_\_ Yes No
With panoramic radiographs (large x-ray) \_\_\_\_\_  
With intraoral radiographs (small x-rays) \_\_\_\_\_

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications. It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

**Operative precautions—For use by the professional**



**Medical history**

Yes No

1. Would you like to speak privately with your dentist?   **Reason, details and date** \_\_\_\_\_
2. Are you being treated by a physician?   \_\_\_\_\_
3. Have you ever had surgery or been hospitalized?   \_\_\_\_\_
4. Do you have joint prostheses (hip, knee, etc.)?   \_\_\_\_\_
5. Have you gained or lost a lot of weight recently?   \_\_\_\_\_
6. Are you pregnant?
7. Are you breastfeeding?
8. Are you taking natural or homeopathic products?   Specify \_\_\_\_\_
9. Are you taking medication?
10. Are you taking birth control  or hormones  ?

**Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months**

Medication and reason	Medication and reason

**Please check Yes or No for each current or past condition**

Yes No

Yes No

- |  |  |
|--|--|
| Blood disorders (hemophilia, anemia, prolonged bleeding) <input type="checkbox"/> <input type="checkbox"/> | Skin diseases <input type="checkbox"/> <input type="checkbox"/>  |
| Heart conditions <input type="checkbox"/> <input type="checkbox"/>   | Eye disorders <input type="checkbox"/> <input type="checkbox"/>  |
| Infarction (heart attack), angina, surgery, etc. <input type="checkbox"/> <input type="checkbox"/>         | Earaches <input type="checkbox"/> <input type="checkbox"/>   |
| Heart infection (endocarditis) <input type="checkbox"/> <input type="checkbox"/>                           | Arthritis <input type="checkbox"/> <input type="checkbox"/>  |
| Surgery to replace or repair a valve /cusp <input type="checkbox"/> <input type="checkbox"/>               | Osteoporosis <input type="checkbox"/> <input type="checkbox"/>   |
| Blood pressure high <input type="checkbox"/> low <input type="checkbox"/>                                  | Prevention / treatment (e.g.: tablets) <input type="checkbox"/> <input type="checkbox"/>   |
| Dizziness, fainting <input type="checkbox"/> <input type="checkbox"/>                                      | Annual or monthly injection <input type="checkbox"/> <input type="checkbox"/>  |
| Frequent headaches <input type="checkbox"/> <input type="checkbox"/>                                       | Chronic pain <input type="checkbox"/> <input type="checkbox"/>   |
| Jaw pain <input type="checkbox"/> <input type="checkbox"/>   | Epilepsy <input type="checkbox"/> <input type="checkbox"/>   |
| Liver disorders (hepatitis A, B, C, cirrhosis, etc.) <input type="checkbox"/> <input type="checkbox"/>     | Nervous system disorders or diseases <input type="checkbox"/> <input type="checkbox"/>   |
| Digestive system disorders or diseases <input type="checkbox"/> <input type="checkbox"/>                   | Mental disorders or illnesses <input type="checkbox"/> <input type="checkbox"/>  |
| Specify _____  | Frequent colds or sinusitis <input type="checkbox"/> <input type="checkbox"/>  |
| Stomach disorders ulcer <input type="checkbox"/> reflux <input type="checkbox"/>                           | Tuberculosis or lung disorders <input type="checkbox"/> <input type="checkbox"/>   |
| Kidney disorders <input type="checkbox"/> <input type="checkbox"/>   | Asthma <input type="checkbox"/> <input type="checkbox"/>   |
| Diabetes <input type="checkbox"/> <input type="checkbox"/>   | Hay fever / seasonal allergies <input type="checkbox"/> <input type="checkbox"/>   |
| Thyroid disorders <input type="checkbox"/> <input type="checkbox"/>  | Allergy or manifestation with products containing:   |
| Cancer (tumour) Specify _____ <input type="checkbox"/> <input type="checkbox"/>                            | Latex <input type="checkbox"/> <input type="checkbox"/> Sulfonamides <input type="checkbox"/> <input type="checkbox"/>                 |
| Radiotherapy <input type="checkbox"/> <input type="checkbox"/>   | Penicillin <input type="checkbox"/> <input type="checkbox"/> Anesthetic <input type="checkbox"/> <input type="checkbox"/>              |
| Chemotherapy <input type="checkbox"/> <input type="checkbox"/>   | Other antibiotics <input type="checkbox"/> <input type="checkbox"/> Food <input type="checkbox"/> <input type="checkbox"/>             |
| Do you suffer from dry mouth? <input type="checkbox"/> <input type="checkbox"/>                            | Codeine <input type="checkbox"/> <input type="checkbox"/> Iodine-containing products <input type="checkbox"/> <input type="checkbox"/> |
| Sexually transmitted or blood-borne infections (STBBI) <input type="checkbox"/> <input type="checkbox"/>   | Aspirin <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>               |
| Specify _____  | Other medical conditions that should be mentioned: _____   |

**Other aspects**

- Do you snore?
- Do you suffer from sleep apnea?
- Do you smoke? \_\_\_ cig./day or ex-smoker
- Do you drink alcohol?
- Frequency: \_\_\_ drinks  /day  /week  /month
- Do you take drugs?
- Do you take methadone?

**Section reserved for the dentist's special notes**

\_\_\_\_\_

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