Confidential Medical Form

Personal Information

Last name: _____ First name: _____ Sex: ○ F ○ M

Address: _____ City: _____ Postal code: _____

Home telephone No: _____ Work telephone No: _____ Ext: _____

Cell: _____ E-mail: _____ Birth date (MM/DD/YYYY): _____

Medicare Card No: _____ Expiry: Year: _____ Month: _____

Social Insurance No. (optional): _____

If you are less than 18 y-o, indicate name of parent/guardian: _____ ○ Parent or ○ Guardian

In case of emergency call: _____

Reason for visit: _____ Referred by: _____

Medical History

Weight: _____ Height: _____ Are you currently under the care of a physician? ○ yes ○ no

If so, reason: _____

Physician's name: _____ Physician's Telephone No: _____

Are you currently taking or have you taken any medication in the last six months? ○ yes ○ no

If yes, please describe them: _____

Are you presently taking natural or homeopathic products? ○ yes ○ no Specify: _____

Are you taking birth control pills? ○ yes ○ no Hormones? ○ yes ○ no Specify: _____

Did you have a weight loss or gain lately? ○ yes ○ no

Are you pregnant? ○ yes ○ no Are you breastfeeding? ○ yes ○ no

Do you or have you ever had any of the following:

Heart disease	○ yes	○ no	Rheumatic fever	○ yes	○ no
Hemophilia	○ yes	○ no	Prolonged bleeding	○ yes	○ no
Clear blood	○ yes	○ no	Anemia	○ yes	○ no
Other blood problems?	_____				
High or low blood pressure:	○ Normal	○ Low	○ High		
Frequent colds or sinusitis	○ yes	○ no	Tuberculosis or lung problems	○ yes	○ no
Digestive problems	○ yes	○ no	Specify the digestive problem: _____		
Stomach ulcers	○ yes	○ no	Liver problems (hepatitis A, B, C or cirrhosis)	○ yes	○ no
Kidney problems	○ yes	○ no	Do you urinate often?	○ yes	○ no
Sexually transmitted infections	○ yes	○ no	Diabetes	○ yes	○ no
Thyroid problems	○ yes	○ no	Skin disease	○ yes	○ no
Vision problems	○ yes	○ no	Arthritis	○ yes	○ no
Osteoporosis	○ yes	○ no	Do you take biphosphonates?	○ yes	○ no
Epilepsy	○ yes	○ no	Nerve problems	○ yes	○ no
Mental illness	○ yes	○ no	Specify the illness: _____		
Frequent headaches	○ yes	○ no	Dizziness or fainting	○ yes	○ no

Earaches	○ yes ○ no	Hay fever	○ yes ○ no		
Asthma	○ yes ○ no	Do you smoke?	○ yes ○ no ○ sometimes		
Have you ever had radiation treatments or chemotherapy?	○ yes ○ no	Do you have AIDS?	○ yes ○ no		
Have you tested positive for AIDS?	○ yes ○ no	Do you have any artificial joints?	○ yes ○ no		

Do you snore or have you ever been told that you snore? ○ yes ○ no

Have you ever had an allergic reaction to any of the following:

Foods	○ yes ○ no	Latex	○ yes ○ no	Penicillin	○ yes ○ no
Aspirin	○ yes ○ no	Iodine	○ yes ○ no	Sulpha drugs	○ yes ○ no
Codeine	○ yes ○ no	Local anesthetic	○ yes ○ no	Other antibiotics	○ yes ○ no

Other products, please specify: _____

Do you use drugs? ○ yes ○ no

Do you drink alcohol? ○ No/A little ○ In Moderation ○ A lot

Have you ever been hospitalized or had surgery other than dental? ○ yes ○ no

If yes, specify the type of surgery and when? _____

Do you fear dental treatments? ○ yes ○ no

Do you wish to discuss your health privetaly with your dentist? ○ yes ○ no

Comments:

Dental History

Date of last dental visit: ○ 0-6 months ○ 6-12 months ○ + than 12 months

Treatment received: _____

Have you had any of the following dental treatments or services?

Oral hygiene demonstration	○ yes ○ no	Gum treatment	○ yes ○ no
Orthodontic treatment (braces)	○ yes ○ no	Root canal treatment	○ yes ○ no
Fillings	○ yes ○ no	Crown(s) or bridge(s)	○ yes ○ no
Full or partial dentures	○ yes ○ no	Dental surgery or extraction	○ yes ○ no
Dental implants	○ yes ○ no	Dental X-rays	○ yes ○ no
Others	○ yes ○ no		

For professional use only:

RESERVED FOR DENTIST'S USE

I acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.

Signature: _____ Date: _____

I, the undersigned, hereby declare that I have read, understood, informed myself about and answered the medical-dental questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my health. I authorize the creation of my dental chart, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my chart will be kept in the office at all times and that only the dentist(s) and his/her (their) support staff will have access to it. I have also been informed of my right to consult my chart, to request that it be corrected and to remove my name from the recall list.

Signature: _____ Date: _____