ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

Ordre des dentistes du Québec

CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

The information contained in the medical-dental questionnaire is necessary for the provision of dental care. Your dental record is protected by law and professional secrecy. It is kept in the office and only the dentist and authorized personnel may consult it and make entries.

Personal Information

First name _____

Last name _____

Gender F ○ M ○ X ○

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

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

Modification(s) _____ Date YY/MM/DD

Medical history

		Yes	No
1.	Would you like to speak privately with your dentist?	○	○
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?	○	○
9.	Are you taking medication?	○	○
10.	Are you taking birth control ○ or hormones ○?	○	○

Reason, details and date

_____

_____

_____

_____

Specify _____

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
Blood disorders (hemophilia, anemia, prolonged bleeding)	○	○
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	○	○
Heart infection (endocarditis)	○	○
Surgery to replace or repair a valve / cusp	○	○
Blood pressure high ○ low ○	○	○
Dizziness, fainting	○	○
Frequent headaches	○	○
Jaw pain	○	○
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	○	○
Digestive system disorders or diseases	○	○
Specify _____		
Stomach disorders ulcer ○ reflux ○	○	○
Kidney disorders	○	○
Diabetes	○	○
Thyroid disorders	○	○
Cancer (tumour) Specify _____	○	○
Radiotherapy	○	○
Chemotherapy	○	○
Do you suffer from dry mouth?	○	○
Sexually transmitted or blood-borne infections (STBBI)	○	○
Specify _____		

	Yes	No
Skin diseases	○	○
Eye disorders	○	○
Earaches	○	○
Arthritis	○	○
Osteoporosis	○	○
Prevention / treatment (e.g.: tablets)	○	○
Annual or monthly injection	○	○
Chronic pain	○	○
Epilepsy	○	○
Nervous system disorders or diseases	○	○
Mental disorders or illnesses	○	○
Frequent colds or sinusitis	○	○
Tuberculosis or lung disorders	○	○
Asthma	○	○
Hay fever / seasonal allergies	○	○
Allergy or manifestation with products containing:		
Latex ○ ○	Sulfonamides ○ ○	
Penicillin ○ ○	Anesthetic ○ ○	
Other antibiotics ○ ○	Food ○ ○	
Codeine ○ ○	Iodine-containing products ○ ○	
Aspirin ○ ○	Other: _____ ○ ○	

Other medical conditions that should be mentioned:

_____

Other aspects

	Yes	No
Have you ever been told that you snore or seem to stop breathing while you sleep?	○	○
Do you wake up tired in the morning and/or feel tired during the day?	○	○
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 use cannabis?	○	○
Do you take other drugs?	○	○
Do you take methadone?	○	○

Section reserved for the dentist's special notes

Consent and identification

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

YY/MM/DD

Patient or authorized person's signature* Date

Name in print

*If the patient is a minor under 14 years of age: the holder of parental authority (including the parent) or the guardian. If the patient is a minor aged 14 or over: the minor, the holder of parental authority (including the parent) or the guardian.

I have reviewed the medical-dental questionnaire and reported any changes in my health since the previous visit.

YY/MM/DD

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

2024-01

This form is printed on FSC® certified paper made from 100% post-consumer recycled fibers.