

Consent to communicate with a health professional

Family physician, specialist, pharmacist, other

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 _____

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

Mr. Ms. _____
Name in print

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

Signature _____	Date <u>YYMM/DD</u>	Signature _____	Date <u>YYMM/DD</u>
Signature _____	Date <u>YYMM/DD</u>	Signature _____	Date <u>YYMM/DD</u>
Signature _____	Date <u>YYMM/DD</u>	Signature _____	Date <u>YYMM/DD</u>
Signature _____	Date <u>YYMM/DD</u>	Signature _____	Date <u>YYMM/DD</u>



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 YYMM/DD
 Health Ins. No. _____ Expiry YYMM
 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

- | | | |
|--|---|---------------|
| 1. Would you like to speak privately with your dentist? | <input type="checkbox"/> <input type="checkbox"/> | Yes No |
| 2. Are you being treated by a physician? | <input type="checkbox"/> <input type="checkbox"/> | |
| 3. Have you ever had surgery or been hospitalized? | <input type="checkbox"/> <input type="checkbox"/> | |
| 4. Do you have joint prostheses (hip, knee, etc.)? | <input type="checkbox"/> <input type="checkbox"/> | |
| 5. Have you gained or lost a lot of weight recently? | <input type="checkbox"/> <input type="checkbox"/> | |
| 6. Are you pregnant? | <input type="checkbox"/> <input type="checkbox"/> | |
| 7. Are you breastfeeding? | <input type="checkbox"/> <input type="checkbox"/> | |
| 8. Are you taking natural or homeopathic products? | <input type="checkbox"/> <input type="checkbox"/> | Specify _____ |
| 9. Are you taking medication? | <input type="checkbox"/> <input type="checkbox"/> | |
| 10. Are you taking birth control <input type="checkbox"/> or hormones <input type="checkbox"/> ? | <input type="checkbox"/> <input type="checkbox"/> | |

Reason, details and date

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			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"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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
