

**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.

Patient \_\_\_\_\_

**Medical history**

Yes No

1. Would you like to speak privately with your dentist?  Yes  No

2. Are you being treated by a physician?  Yes  No

3. Have you ever had surgery or been hospitalized?  Yes  No

4. Do you have joint prostheses (hip, knee, etc.)?  Yes  No

5. Have you gained or lost a lot of weight recently?  Yes  No

6. Are you pregnant?  Yes  No

7. Are you breastfeeding?  Yes  No

8. Are you taking natural or homeopathic products?  Yes  No

Specify \_\_\_\_\_

9. Are you taking medication?  Yes  No

10. Are you taking birth control  or hormones  ?  Yes  No

**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)  Yes  No

Heart conditions

Infection (heart attack, angina, surgery, etc.)  Yes  No

Heart infection (endocarditis)  Yes  No

Surgery to replace or repair a valve /cusp  Yes  No

Blood pressure  high  low  Yes  No

Dizziness, fainting  Yes  No

Frequent headaches  Yes  No

Jaw pain  Yes  No

Liver disorders (hepatitis A, B, C, cirrhosis, etc.)  Yes  No

Digestive system disorders or diseases  Yes  No

Specify \_\_\_\_\_

Stomach disorders  Yes  No

ulcer  reflux  Yes  No

Kidney disorders  Yes  No

Diabetes  Yes  No

Thyroid disorders  Yes  No

Cancer (tumour) Specify \_\_\_\_\_  Yes  No

Radiotherapy  Yes  No

Chemotherapy  Yes  No

Do you suffer from dry mouth?  Yes  No

Sexually transmitted or blood-borne infections (STBI)  Yes  No

Specify \_\_\_\_\_

**Other aspects**

Do you snore?  Yes  No

Do you suffer from sleep apnea?  Yes  No

Do you smoke?  Yes  No

Do you drink alcohol?  Yes  No

Frequency: \_\_\_\_\_ drinks  /day  /week  /month  Yes  No

Do you take drugs?  Yes  No

Do you take methadone?  Yes  No

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other medical conditions that should be mentioned: \_\_\_\_\_

- 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
  - Anesthetic
  - Food
  - Other antibiotics
  - Codeine
  - Aspirin
- Iodine-containing products
- Other: \_\_\_\_\_