Spécialistes chirurgie buccale & maxillo-faciale

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CONFIDENTIAL INTRODUCTION QUESTIONNAIRE

M : ☐ F : ☐ Name : ____________ First name : ____________
Address : ____________ Apt # ____________
City : ____________ Country : ____________ Postal code : ____________
Phone : Home : ____________ Work : ____________ Ext. ____________
Cell : ____________ Date of birth : ______/______/______ Weight : ____________
E-Mail address : ____________ Guardian if minor : ____________
Medicare number : ______ ______ ______ **Expiration date :** ______/______
Referred by : ____________
Reason of your appointment : ____________
Do you have dental insurance? yes ☐ no ☐ Are you receiving social assistance? yes ☐ no ☐

Medical History :

1. Are you presently under a doctor's care ? yes ☐ no ☐
   Attending physician : ____________ Phone : ____________
2. Are you presently taking any drug or medication ? (including injections to combat osteoporosis ex : Aredia ®, Aclasta ®, Zometa ®, Prolia ® ...)
   yes ☐ no ☐ If so, which ? ____________

	yes	no
3. Are you pregnant ?	☐	☐
4. Heart disease ?	☐	☐
5. Rheumatic fever ?	☐	☐
6. Prolonged bleeding ?	☐	☐
7. Anemia ?	☐	☐
8. Blood pressure ? High ☐ Low ☐	☐	☐
9. Frequent colds or sinusitis	☐	☐
10. Tuberculosis or lung problems ?	☐	☐
11. Digestive problems ?	☐	☐
12. Liver disease ? (hepatisis A or B, cirrhosis, etc)	☐	☐
13. Kidney disease ?	☐	☐
14. Venereal disease ?	☐	☐
15. Diabetes ?	☐	☐
16. Thyroid problems ?	☐	☐
17. Skin disease ?	☐	☐
18. Eye problems ?	☐	☐
19. Arthritis ?	☐	☐
20. Epilepsy ?	☐	☐
21. Nervous disorder ?	☐	☐
22. Frequent headaches ?	☐	☐
23. Fainting spells ?	☐	☐
24. Earaches ?	☐	☐
25. Hay fever ?	☐	☐
26. Asthma ?	☐	☐

27. Do you have any of the following allergies :

	yes	no		yes	no
Food	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Sulfonamides	☐	☐
Aspirin	☐	☐	Anesthesia	☐	☐

Others ? ____________

28. Have you ever had radiotherapy or/and chemotherapy treatments (tumor) ? yes ☐ no ☐
29. Are you an AIDS virus carrier ? yes ☐ no ☐

Dental History :

Last visit: 0-6 months ☐ 6-12 months ☐ + than 12 months ☐ Treatments : ____________
Have you previously had dental treatments such as :

	yes	no
1. Oral hygiene instruction ?	☐	☐
2. Gum treatment ?	☐	☐
3. Orthodontic treatment ?	☐	☐
4. Root canal treatment ?	☐	☐
5. Dental filling ?	☐	☐
6. Crown or/and bridge ?	☐	☐
7. Partial or/and complete denture ?	☐	☐
8. Surgical treatment or extraction ?	☐	☐
9. X-Rays ? When : ____________	☐	☐
10. Other ? ____________		

Were you ever hospitalized or have you undergone surgery other than dental ? yes ☐ no ☐
If so, indicate which ones and when ? ____________

Do you wish to add information about your health in general ? ____________

I, the undersigned, hereby declare that I have read, understood, asked for explanation where I did not understand and answered the above medical-dental questionnaire to the best of my knowledge.

Date : ____________ Signature : ____________ Signature of surgeon : ____________