MICHEL MALBOEUF
CENTRE DENTAIRE

Confidential dental-medical questionnaire

Last name:

First name: FILE No:

Medical history:

Attending physician: Name: Tel. :

	NO	YES	DATE
• Are you presently under a doctor's care?			
• Are you presently taking any medication or have you taken any medication? If yes, since when? Quantity per day:			
	NO	**YES**	**N/A**
• Are you pregnant?			
• Are you taking oral contraceptives?			
• Do you smoke (cigarettes, cigars, pipe, cannabis, others)? If yes, since when? Quantity per day			
• Are you taking any medications for osteoporosis? NO YES: Orally Annual injections Since when?			

Are you suffering or have ever suffered from:

	NO	YES	DATE
• Heart diseases? (Stroke, angina, valvular problems, murmur)?			
• Rheumatic fever?			
• Prolonged bleeding?			
• Anemia?			
• Blood pressure High Low			
• Pressure: / I don't know			
• Frequent colds or sinus infections?			
• Tuberculosis or lung problems?			
• Digestive problems?			
• Stomach ulcers?			
• Liver diseases? (Hepatitis A, B, C, cirrhosis, etc.)?			
• Kidney diseases?			
• Sexually transmitted diseases?			
• Diabetes?			
• Thyroid problems?			
• Skin diseases?			
• Eye problems?			
• Arthritis?			
• Epilepsy?			
• Nervous disorders?			
• Frequent headaches?			
• Dizzy spells and/or fainting spells?			

Are you suffering or have ever suffered from:

	NO	YES
• Earaches?		
• Hay fever?		
• Asthma?		
• Have you ever had radiotherapy and / or chemotherapy treatments?		
• Do you have aids?		
• Are you HIV positive?		
• Do you have an artificial joint (knee, hip, etc.)?		

- Do you have any of the following allergies?

	NO	YES		NO	YES		NO	YES		NO	YES
Food			Local anesthetics			Penicillin			Latex		
Iodine			Aspirin			Sulfa			Codeine		

Others

	NO	YES
• Are you allergic or sensitive to Mercury in dental amalgams (conventional gray fillings)?		
• Have you ever been hospitalized or have you undergone surgery other than dental?		

If so, indicate which ones and when:

I, the undersigned, hereby declare that I have read, understood and answered the above medical-above questionnaire to the best of my knowledge. I also hereby promise to inform you of any changes to my health.

Signature (patient or guardian) Date

I acknowledge, that I have read the answers to the above questionnaire and I have taken the necessary measures, as the case may be.

Signature (attending dentist) Date