CLINIQUE DENTWEST INC.
6332 Sherbrooke W #203
Montreal, QC, H4B 1M7

Medical / dental questionaire

Name: ______________________ Sex: ______
Address: ______________________ File Number:
City: ______________ Postal Code: ________ Tel. Home:
Birthday: ____________ Office:
E-Mail: ______________________

Please circle the right answer

MEDICAL HISTORY

Are you under a doctor's care .... Y N

Do you suffer or have you suffered from

- Heart ailments .... Y N
- Rheumatic fever .... Y N
- Hight/low blood pressure .... Y N
- Asthma .... Y N
- Anemia .... Y N
- Tuberculosis, lung ailments .... Y N
- Diabetes .... Y N
- Liver problems,hepatitis,cirrho. .... Y N
- Kidney problems .... Y N
- Venereal disease .... Y N
- AIDS .... Y N
- Eye trouble .... Y N
- Arthritis .... Y N
- Epilepsy .... Y N
- Nervous complaints .... Y N
- Thyroid trouble .... Y N
- Digestive problems .... Y N
- Prolonged bleeding .... Y N
- Stomach ulcer .... Y N
- Do you have artifical joints? .... Y N
- Frequent headaches .... Y N
- Loss of consciousness .... Y N
- Ear infections .... Y N
- Do you suffer from allergies:
  - Hay fever .... Y N
  - Penicillin .... Y N
  - Aspirin .... Y N
  - Iodine .... Y N
  - Sulfamides .... Y N
  - Local anesthetics .... Y N
  - Other antibiotics: ____________
  - Other allergies: ____________

Are you pregnant Y N

Are you scared of dental treatments Y N
Are you pleased with your smile Y N
What would you like to change
____

Do you take
- Birth control pills .... Y N
- Medication .... Y N

List present medication
____

Are you smoker .... Y N

Have you received
- Radiotherapeutic treatments .... Y N

Surgery date (yyyy: mm)
______________________ (:)
______________________ (:)
______________________ (:)

DENTAL HISTORY.

When was your last dental appointment: ____________

Have you had
- Gum treatments .... Y N
- Hemorraging .... Y N
- Orthodontic treatment .... Y N
- Root canal work .... Y N
- Teeth extraction / oral surgery .... Y N
- Dental xrays .... Y N

Do you have
- Pain / difficulty when opening your mouth .... Y N
- Bleeding of gums .... Y N
- Unreplaced missing teeth .... Y N
- Loose teeth .... Y N

Referred by: ______________________
Responsible for payments:
☐ Self ☐ RAMQ
☐ Insurance: ☐ Other
RAMQ ____________ Exp.: ______

Medical questionnaire revision	Date	Initials
Note:		

Reason of visit: ______________________

Signature of patient: ____________ Signature of dentist: ____________ Date: ________

2006.10.27