Medical Questionnaire

Last Name: _____First Name:_____ DOB: _____ Gender M F
Address: _____ City: _____ Postal Code: _____
Phone (1) :_____(2) :_____ E-mail:_____
Occupation: _____ Emergency contact: _____
RAMQ: _____ Exp : _____ Insurance: _____
Doctor's name and specialty: _____ Allergies: _____
Date and reason for last medical exam: _____ Family members: _____
How would you rate your general health? □ Excellent □ Good □ Moderate □ Poor

Have you ever:	**YES**	**NO**
1. Been hospitalized for an injury or illness	□	□
2. Had an allergic reaction to the following:		
Aspirin, ibuprofen, acetaminophen	□	□
Penicillin	□	□
Erythromycin	□	□
Tetracycline	□	□
Codeine	□	□
Local Anaesthesia	□	□
Fluoride	□	□
Metals (cobalt, nickel, etc.)	□	□
Latex	□	□
Other medications	□	□
3. Cardiac problems	□	□
4. Problems with taste or smell	□	□
5. Rheumatic fever	□	□
6. Scarlet Fever	□	□
7. High Blood Pressure	□	□
8. Low blood pressure	□	□
9. Cerebral vascular stroke	□	□
10. Artificial Heart valve	□	□
11. Anemia or other blood problems	□	□
12. Hemophilia	□	□
13. Emphysema	□	□
14. Tuberculosis	□	□
15. Asthma	□	□
16. Sleep or respiratory problems (snoring, sinus)	□	□
17. Kidney disease	□	□
18. Liver problems	□	□
19. Jaundice	□	□
20. Thyroid problem	□	□
21. Hormonal deficiency	□	□
22. Cholesterol problems	□	□
23. Diabetes	□	□

	YES	**NO**
25. Digestive problems (acid reflux, gastritis)	□	□
26. Arthritis	□	□
27. Glaucoma	□	□
28. Contact lenses	□	□
29. Head or neck injury	□	□
30. Epilepsy or convulsions	□	□
31. Neurological disease	□	□
32. Viral infections or cold sores	□	□
33. Bumps or swelling in the mouth	□	□
34. Hives or hay fever	□	□
35. Sexually transmitted diseases	□	□
36. Hepatitis, which type	□	□
24. Stomach ulcer or duodenal	□	□
37. HIV- Aids	□	□
38. Tumours	□	□
39. Radiotherapy	□	□
40. Chemotherapy	□	□
41. Depression	□	□
42. Psychiatric treatment	□	□
43. Antidepressant medication	□	□
44. Alcoholism or addiction	□	□
Are you:		
45. Presently under treatment for a medical issue	□	□
46. Aware of any change in you general health	□	□
47. Treated for osteoporosis	□	□
48. Often tired or exhausted	□	□
49. Suffer from frequent headaches/migraines	□	□
50. A smoker or ex-smoker	□	□
51. Often unhappy or depressed	□	□
52. WOMEN: Taking birth-control	□	□
53. WOMEN: Pregnant	□	□
54. MEN: suffering from a prostate disorder	□	□

Please describe all other medical or surgical treatment that may affect your dental treatments:

_____

Please list all medications, supplements and or vitamins taken in the last 2 years

Medications	Reason	Medications	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you have more the 6 medications, we can provide you with another paper

Please advise us of any changes in your medical history as well as you medication.

Patient Signature_____ **Date** _____

Dentist Signature_____ **Date** _____