Centre dentaire Dinh & Tran inc.
5605 chemin Chambly, Saint-Hubert J3Y 3P9

MEDICAL HISTORY

Reason of visit: ____________________

List present medication:

____

____

____

Referred by: ____________________

Payments: Insurance ☐ RAMQ ☐ $ ☐ Visa, Interac, Mastercard ☐

The undersigned hereby declare that I have read, understood and answered the above medical/dental questionnaire to the best of my knowledge. I also promise to inform you of any change to my health. I authorize the setting-up of my dental file. It's follow-up, as well as my registration on the recall list of the attending dentist (s). I have been informed of my right to consult my file, to request that it be corrected if necessary and to remove me name from the recall list.

Signature of patient or guardian: ____________________ Date: ____________________

FOR THE PHYSICIAN'S USE ONLY

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

Signature attending dentist: ____________________ Date: ____________________

Note: ____________________

____

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MEDICAL HISTORY

E-Mail :___________________________________

RAMQ card : Exp :

For a emergency contact : **Phone number :**

	Yes	No
Are you presently under a doctor's care?	☐	☐
Are you presently taking medication?	☐	☐

Do you suffer or have you suffered from

	Yes	No
Heart ailments	☐	☐
Rheumatic fever	☐	☐
Blood pressure Hi ___ Low ___	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis, lung problem Asthme	☐	☐
Digestive problems	☐	☐
Stomach ulcer	☐	☐
Kidney problems	☐	☐
Frequent urine	☐	☐
Venereal disease (DV)	☐	☐
Diabetes	☐	☐
Liver disease hepatitis: ______ cirrhosis	☐	☐
Thyroid problem	☐	☐
Skin disease ________________	☐	☐
Eye Problems	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Frequent headaches	☐	☐
Dizzy spells or fainting spells	☐	☐
Epilepsy	☐	☐
Nervous disorders	☐	☐
Mental illness	☐	☐

Allergies:

Penicillin	☐	☐	Codeine	☐	☐
Antibiotics	☐	☐	Anesthetises	☐	☐
Iodine	☐	☐	Aspirin	☐	☐
Latex	☐	☐	Sulfamides	☐	☐
Others: ____________________________				☐	☐

Are you pregnant?	☐	☐
Are you breastfeeding?	☐	☐

	Yes	No
Are you an AIDS virus carrier?	☐	☐
Do you have AIDS symptoms?	☐	☐
Do you consume many drugs?	☐	☐
Do you smoke?	☐	☐
Surgery	☐	☐

Which: **(date)**
____________________________ (:)
____________________________ (:)
____________________________ (:)

Have you ever had radiotherapy or/and chemotherapy treatments (tumor)?	☐	☐
Do you snore?	☐	☐
Earaches?	☐	☐
Do you fear dental treatments?	☐	☐

DENTAL HISTORY

Last visit:

0 – 6 months __ 6 – 12 months __ 12 months + __

Do you visit a specialist	☐	☐
Oral hygiene instructions	☐	☐
Xrays	☐	☐
Gum treatments, periodontitis	☐	☐
Dental Fillings	☐	☐
Root canal work	☐	☐
Surgical treatment	☐	☐
Extraction	☐	☐
Crown / Bridge	☐	☐
Partial or/and complete dental	☐	☐
Orthodontic treatments	☐	☐
Implants	☐	☐
Others: ____________________	☐	☐