# Confidential Medical Form

**Personal Information**

Last name: _____ First name: _____ Sex: ○ F ○ M

Address: _____ City: _____ Postal code: _____

Home telephone No: _____ Work telephone No: _____ Ext: _____

Cell: _____ E-mail: _____ Birth date (MM/DD/YYYY): _____

Medicare Card No: _____ Expiry: Year: _____ Month: _____

Social Insurance No. (optional): _____

If you are less than 18 y-o, indicate name of parent/guardian: _____ ○ Parent or ○ Guardian

In case of emergency call: _____

Reason for visit: _____ Referred by: _____

**Medical History**

Weight: _____ Height: _____ Are you currently under the care of a physician? ○ yes ○ no

If so, reason: _____

Physician's name: _____ Physician's Telephone No: _____

Are you currently taking or have you taken any medication in the last six months? ○ yes ○ no

If yes, please describe them: _____

Are you presently taking natural or homeopathic products? ○ yes ○ no Specify: _____

Are you taking birth control pills? ○ yes ○ no Hormones? ○ yes ○ no Specify: _____

Did you have a weight loss or gain lately? ○ yes ○ no

Are you pregnant? ○ yes ○ no Are you breastfeeding? ○ yes ○ no

**Do you or have you ever had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Heart disease | ○ yes | ○ no | Rheumatic fever | ○ yes | ○ no |
| Hemophilia | ○ yes | ○ no | Prolonged bleeding | ○ yes | ○ no |
| Clear blood | ○ yes | ○ no | Anemia | ○ yes | ○ no |
| Other blood problems? | _____ | | | | |
| High or low blood pressure: | ○ Normal | ○ Low | ○ High | | |
| Frequent colds or sinusitis | ○ yes | ○ no | Tuberculosis or lung problems | ○ yes | ○ no |
| Digestive problems | ○ yes | ○ no | Specify the digestive problem: _____ | | |
| Stomach ulcers | ○ yes | ○ no | Liver problems (hepatitis A, B, C or cirrhosis) | ○ yes | ○ no |
| Kidney problems | ○ yes | ○ no | Do you urinate often? | ○ yes | ○ no |
| Sexually transmitted infections | ○ yes | ○ no | Diabetes | ○ yes | ○ no |
| Thyroid problems | ○ yes | ○ no | Skin disease | ○ yes | ○ no |
| Vision problems | ○ yes | ○ no | Arthritis | ○ yes | ○ no |
| Osteoporosis | ○ yes | ○ no | Do you take biphosphonates? | ○ yes | ○ no |
| Epilepsy | ○ yes | ○ no | Nerve problems | ○ yes | ○ no |
| Mental illness | ○ yes | ○ no | Specify the illness: _____ | | |
| Frequent headaches | ○ yes | ○ no | Dizziness or fainting | ○ yes | ○ no |

| | | | | | |
|---|---|---|---|---|---|
| Earaches | ○ yes ○ no | Hay fever | ○ yes ○ no | | |
| Asthma | ○ yes ○ no | Do you smoke? | ○ yes ○ no ○ sometimes | | |
| Have you ever had radiation treatments or chemotherapy? | ○ yes ○ no | Do you have AIDS? | ○ yes ○ no | | |
| Have you tested positive for AIDS? | ○ yes ○ no | Do you have any artificial joints? | ○ yes ○ no | | |

Do you snore or have you ever been told that you snore? ○ yes ○ no

**Have you ever had an allergic reaction to any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Foods | ○ yes ○ no | Latex | ○ yes ○ no | Penicillin | ○ yes ○ no |
| Aspirin | ○ yes ○ no | Iodine | ○ yes ○ no | Sulpha drugs | ○ yes ○ no |
| Codeine | ○ yes ○ no | Local anesthetic | ○ yes ○ no | Other antibiotics | ○ yes ○ no |

Other products, please specify: _____

Do you use drugs? ○ yes ○ no

Do you drink alcohol? ○ No/A little ○ In Moderation ○ A lot

Have you ever been hospitalized or had surgery other than dental? ○ yes ○ no

If yes, specify the type of surgery and when? _____

Do you fear dental treatments? ○ yes ○ no

Do you wish to discuss your health privetaly with your dentist? ○ yes ○ no

Comments:

**Dental History**

Date of last dental visit: ○ 0-6 months ○ 6-12 months ○ + than 12 months

Treatment received: _____

**Have you had any of the following dental treatments or services?**

| | | | |
|---|---|---|---|
| Oral hygiene demonstration | ○ yes ○ no | Gum treatment | ○ yes ○ no |
| Orthodontic treatment (braces) | ○ yes ○ no | Root canal treatment | ○ yes ○ no |
| Fillings | ○ yes ○ no | Crown(s) or bridge(s) | ○ yes ○ no |
| Full or partial dentures | ○ yes ○ no | Dental surgery or extraction | ○ yes ○ no |
| Dental implants | ○ yes ○ no | Dental X-rays | ○ yes ○ no |
| Others | ○ yes ○ no | | |

**For professional use only:**

RESERVED FOR DENTIST'S USE

I acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.

Signature: _____ Date: _____

I, the undersigned, hereby declare that I have read, understood, informed myself about and answered the medical-dental questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my health. I authorize the creation of my dental chart, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my chart will be kept in the office at all times and that only the dentist(s) and his/her (their) support staff will have access to it. I have also been informed of my right to consult my chart, to request that it be corrected and to remove my name from the recall list.

Signature: _____ Date: _____