ACDQ
ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

Ordre des dentistes du Québec

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M ❑ F ❑ Last Name: _____ First Name: _____

Address: N° : _____ Street: _____ Apt.: _____

City: _____ Postal Code: _____

Tel. Res.: _____ Work: _____ Cell.: _____

Birthdate: Year: _____ Month: _____ Day: _____ E-mail: _____

Medicare No.: _____ Expiry Date: _____ Social Insurance No. (optional): _____

If you are less than 18 years old, indicate name of parent ❑ or guardian ❑

_____ Mr. ❑ Mrs. ❑

For an emergency, contact: _____

Motive for visit: _____ Referred by: _____

MEDICAL HISTORY

Weight _____ Height _____

	Yes	No
1. Are you presently under a doctor's care?	❑	❑
If so, reason: _____		
Last Name: _____ First Name: _____		
Tel.: _____ (Ext.): _____		
2. Are you presently taking any drug or medication, or have you taken any in the last six months?	❑	❑
If so, which: _____		
3. Are you presently taking natural or homeopathic products?	❑	❑
Specify: _____		
- Birth control pills	❑	❑
- Hormones: Specify: _____	❑	❑
4. Did you recently experience a significant weight loss or gain?	❑	❑
5. Are you pregnant?	❑	❑
Are you breastfeeding?	❑	❑
Are you suffering or have you ever suffered from:		
6. Heart disease (stroke, angina, valvular problems, murmur)	❑	❑
7. Rheumatic fever	❑	❑
8. Blood problems		
8.1 Hemophilia	❑	❑
8.2 Prolonged bleeding	❑	❑
8.3 Clear blood	❑	❑
8.4 Anemia	❑	❑
8.5 Others: Specify: _____	❑	❑
9. High ❑ Low ❑ Blood pressure	❑	❑
10. Frequent colds or sinusitis	❑	❑
11. Tuberculosis or lung problems	❑	❑
12. Digestive problems: Specify: _____	❑	❑
13. Stomach ulcer	❑	❑
14. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	❑	❑
15. Kidney problems	❑	❑
16. Do you urinate often?	❑	❑
17. Venereal disease (V.D.)	❑	❑
18. Diabetes	❑	❑
19. Thyroid problems	❑	❑
20. Skin disease	❑	❑
21. Eye problems	❑	❑
22. Arthritis	❑	❑
23. Osteoporosis	❑	❑
Do you take bisphosphonates?	❑	❑
24. Epilepsy	❑	❑
25. Nervous disorders	❑	❑
26. Mental illness	❑	❑
Specify: _____		
27. Frequent headaches	❑	❑
28. Dizzy spells or fainting spells	❑	❑
29. Earaches	❑	❑
30. Hay fever	❑	❑
31. Asthma	❑	❑
32. Do you smoke?	❑	❑
33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor)?	❑	❑
34. Do you have AIDS symptoms?	❑	❑
35. Are you an AIDS virus carrier?	❑	❑
36. Do you have artificial joints (knee, hip, etc.)?	❑	❑
37. Do you snore or have you ever been told that you snore?	❑	❑
38. Do you have any of the following allergies?		
38.1 Latex ❑	❑ 38.6 Penicillin	❑ ❑
38.2 Food ❑	❑ 38.7 Codeine	❑ ❑
38.3 Iodine ❑	❑ 38.8 Other antibiotics	❑ ❑
38.4 Aspirin ❑	❑ 38.9 Local anaesthesia	❑ ❑
38.5 Sulfonamides ❑	❑ 38.10 Others	❑ ❑
Specify: _____		
39. Do you use drugs?	❑	❑
40. Do you drink alcohol?		
No/A little ❑ In moderation ❑ A lot ❑		
41. Were you ever hospitalized or have you undergone surgery other than dental?	❑	❑
If so, why and when: _____		
_____ date _____		
_____ date _____		
_____ date _____		
42. Do you fear dental treatments?		
A little ❑ A lot ❑ Not at all ❑		
43. Is there anything concerning your health you wish to discuss privately with your dentist?	❑	❑
Remarks: _____		

SEE REVERSE

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FOR THE PHYSICIAN'S USE ONLY

PRECAUTIONS:

DENTAL HISTORY

Last visit: 0-6 months ❑ 6-12 months ❑ 12 months + ❑

Treatments received: _____

Have you previously had dental treatments such as:	Yes	No		Yes	No
1. Oral hygiene instructions	❑	❑	7. Partial or/and complete denture	❑	❑
2. Gum treatment	❑	❑	8. Surgical treatment or extraction	❑	❑
3. Orthodontic treatment	❑	❑	9. Dental implants	❑	❑
4. Root canal treatment	❑	❑	10. X-rays	❑	❑
5. Dental fillings	❑	❑	11. Others	❑	❑
6. Crown or/and bridge	❑	❑			

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: _____ Date: _____
Attending dentist

TO BE COMPLETED BY PATIENT

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

Signature: _____ Date: _____
Patient or guardian