ORTHODONTIE
CÔTE-DES-NEIGES

CONFIDENTIAL HEALTH AND DENTAL QUESTIONNAIRE

First name: _____ Last name: _____ Gender : ◯ F ◯ M
Address: _____ Apt. #: _____ City: _____
Postal Code: _____ Home phone: _____ Work phone: _____ Ext.: _____
Cell phone: _____ email: _____
Date of birth (Y/M/D): _____ Age: _____
Who may we thank for referring you to our office? _____
Name of your dentist: _____
Object of the consultation: _____

PARENT(S) INFORMATION (IF UNDER 18 YEARS OLD)

Mother's first name: _____ Mother's last name: _____
Cell phone: _____ Work phone: _____ ext. _____ email: _____
Father's first name: _____ Father's last name: _____
Cell phone: _____ Work phone: _____ ext. _____ email: _____
Child's attitude to dentistry _____

DENTAL HISTORY

1. Last dental visit: ◯ 0-6 months ◯ 6-12 months ◯ more than 12 months
2. Treatment received at that last visit: _____

MEDICAL HISTORY

1.	Are you actually under the care of a physician (or specialist, cardiologist, etc.)? If yes, please provide us with the following information: Name of physician: _____ Phone: _____	Yes	No
2.	Do you take any medication or did you take any during the last 6 months? If yes, please write the name and dosage of the medication(s): _____	Yes	No
3.	Have you lost or gained a lot of weight recently?	Yes	No
4.	If you are a woman, are you pregnant?	Yes	No
5.	If you are a woman, do you take contraceptive medication?	Yes	No

DO YOU HAVE OR HAD THE FOLLOWING MEDICAL CONDITION:

6.	Heart related problems (stroke, heart attack, angina, valvular problems, etc.)	Yes	No
7.	Rheumatic fever	Yes	No
8.	Blood disorders (prolonged bleeding, hemophilia)	Yes	No
9.	Anemia	Yes	No
10.	Blood pressure: ◯ High ◯ Low ◯ Normal	Yes	No
11.	Frequent colds or sinusitis	Yes	No
12.	Tuberculosis or pulmonary disease	Yes	No
13.	Digestive disorders	Yes	No
14.	Stomach ulcers	Yes	No
15.	Liver disorders (hepatitis virus A,B,C, cirrhosis, etc.)	Yes	No
16.	Renal disease	Yes	No
17.	Sexually transmitted infection (STI)	Yes	No
18.	Diabetes	Yes	No

back side

19. Thyroid disorder	Yes	No
20. Skin diseases	Yes	No
21. Eye problems	Yes	No
22. Arthritis	Yes	No
23. Epilepsy	Yes	No
24. Nervous disorders	Yes	No
25. Frequent headaches	Yes	No
26. Dizziness or fainting	Yes	No
27. Ear aches	Yes	No
28. Hay fever (seasonal allergies)	Yes	No
29. Asthma	Yes	No

30. Do you smoke? ○ Yes ○ No If yes, how many cigarettes per day?_____ For how many years? _____

31. Have you ever had radiotherapy and/or chemotherapy for a cancer?	Yes	No
If yes, which type of cancer? _____		
32. Have you been given the diagnosis of AIDS?	Yes	No
33. Are you HIV positive?	Yes	No
34. Do you have any prosthetic devices (knee or hip)?	Yes	No
35. Is it recommended by your physician to take antibiotics before a visit at your dentist?	Yes	No

36. Are you allergic or have you had any adverse reaction to the following products?

Latex	○	Food	○	Others	○
Penicillin	○	Iodine	○	Specify :	_____
Aspirin	○	Sulfas	○		_____
Codeine	○	Nickel	○		
Local anesthetics	○	Copper and other metals	○		

38. Have you ever been hospitalized and/or had surgery for any health problem other than dental? Yes No
If yes, when and explain: _____

38. Please, inform us of any other medical problem not mentioned above.

_____

ORTHODONTIC QUESTIONNAIRE

1. Have you ever suffered from a dental, facial or head trauma/accident?
If yes, what kind of trauma: _____ ○ Yes ○ No

2. Do you grind your teeth at night? ○ Yes ○ No

3. Do you have pain, clicking or any symptoms to the jaw/joint?
If yes, please describe: _____ ○ Yes ○ No

4. Have you ever had any previous orthodontic treatment?
If yes, when and what kind of treatment: _____ ○ Yes ○ No

5. Have you ever sucked your thumb/finger? ○ Yes ○ Yes and still have the habit ○ Yes ○ No

6. Do you have tongue or speech problems?
If yes, please describe: _____ ○ Yes ○ No

7. Do you breathe through…? ○ The mouth ○ The nose ○ Both

8. Do you bite your nails? ○ Yes ○ No

I, undersigned, certify that I have read, understood, asked the necessary questions and answered this medical and dental questionnaire to the best of my knowledge. I will inform my dentist of any changes affecting my health. I authorize the opening of my record at this office and its follow-up.

_____ Date_____

Patient signature or parent (if under 18 years old)

_____

Tram-Anh Nguyen, DMD, MSc
Orthodontist