Precautions and Notes For the dentists use only:

Initials of attending dentist:_____

Consent

1. *I, the undersigned, herby declare to have read, understood and answered the preceding Health and Medical Questionnaire honestly and to the best of my knowledge.*

Signature:_____
Signature of guardian(-18):_____

2. *I authorize the setting up of my dental file (diagnosis, treatment and follow-up) and my registration on the recall list(s) of the treating dentist(s).*

   I have been informed that my file will be kept in the office or with my attending dentist 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:_____
Signature of guardian(-18):_____

3. *I authorize the treating dentist(s) to use the contents of my file including my photos, models and radiographs for educational purposes and patient case presentations.*

Signature:_____
Signature of guardian(-18):_____

Clinique dentaire du Portage
Dental Clinic du Portage

Ordre des dentistes du Québec

Confidential Health and Medical Questionnaire

Name:_____
Date:_____

In order for us to best address your needs; please fill out the sections below as clearly and as honestly as possible. Please indicate your answers by placing an "X" in the corresponding box in the right column. Y = Yes N = No

A. ***Principle Reasons for Today's Visit***

1. Please explain briefly the main reason for today's visit.

_____
_____
_____
_____
_____

B. ***Present and Past Medication***

	Y	N
1. Are you presently taking any medication or drugs, with or without prescription, including vitamins and herbs?..... Specify: _____	☐	☐
2. Have you taken any drugs or medication within the last 6 months?…….…. Specify: _____	☐	☐
3. Do you frequently take ibuprophen ☐, Aspirin ☐, acetaminophen (Tylenol) ☐or any other ☐ pain relievers?..... If so, specify why and how much:_____	☐	☐

C. ***Present and Past Illnesses***

1. Are you presently under the care of a physician? ☐ ☐
   Physician's:

Surname:_____
Last Name:_____
Tel.:_____
E-mail:_____

2. Are you *presently* suffering or *have you ever* suffered from any of the following?

	Y	N
a. Childhood diseases…….……..	☐	☐
b. Mumps…….……..	☐	☐
c. Scarlet ☐ or/and Rheumatic ☐fever……	☐	☐
d. Diphtheria……..…..	☐	☐
e. Mastoiditis…….……..	☐	☐
f. Heart disease ……..……....	☐	☐
g. High ☐† and/or Low ☐† blood pressure…….	☐	☐
h. Arteriosclerosis……..…..	☐	☐
i. Cerebral hemorrhage……..……...	☐	☐
j. Hemophilia……..	☐	☐
k. Frequent colds ☐ and/or sinusitis ☐……..…	☐	☐
l. Tuberculosis ☐ and/or lung problems ☐……....	☐	☐
m. Asthma…….……	☐	☐
n. Skin disease……..……..……	☐	☐
o. Diabetes ☐ and/or gestational diabetes ☐.....	☐	☐
p. Liver ☐ and/or Kidney ☐ disease……..…..	☐	☐
q. Hepatitis A ☐, B ☐or C ☐……..……	☐	☐
r. Thyroid problems…….……	☐	☐
s. Arthritis ☐ and/or Gout …….....	☐	☐
t. Rickets……....	☐	☐
u. Venereal disease……..……...	☐	☐
v. Epilepsy……....	☐	☐
w. Psychological or nervous disorders……..	☐	☐
x. Anemia……..…..	☐	☐
y. Cancer……..………	☐	☐
z. Perodontal disease (pyorrhea)……...	☐	☐
3. Do you have AIDS symptoms?……..	☐	☐
4. Are you an AIDS virus carrier?……..	☐	☐
5. Have you ever had radiotherapy and/or chemotherapy (tumor)?…….……	☐	☐
6. Have you ever had had x-ray treatments to the head or neck?……..	☐	☐
7. Have you ever had any specific trauma to the head or face?.....…….	☐	☐
8. Were you ever hospitalized or have you ever undergone surgery other than dental?..... If so, specify below:	☐	☐

a._____

_____date:_____

b._____

_____date:_____

D. *System Review*

1. Please indicate your approximate…
   Weight: _____ Height:_____
2. Are you presently or have you ever experienced any of the following problems?

a. Dizzy or fainting spells……..……	☐	☐
b. Visual disorders…….……..	☐	☐

J. *Anxiety Questionnaire*

If applicable, please *rate your level of anxiousness* in the section below by placing an "x" in the boxes.

	Y	N
1. Are you afraid of going to the dentist?.....	☐	☐

2. If you had a dentist appointment tomorrow, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
3. If you were sitting in the waiting room for a treatment, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
4. If you were at the dental office for a cleaning, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
5. If you were to receive local anesthetic injection (freezing) in your gum, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
6. If the dentist needed to use a drill during your treatment, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
7. If you were to have your teeth scaled and polished, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
8. If the dentist needed to perform a root canal treatment or extractions, you would be […] anxious.
   Slightly ☐, Fairly ☐, Very ☐, Extremely ☐.
9. If we were able to help manage your dental anxiety, would you want us to speak to you about what we can offer you?..... ☐ ☐

K. *General*

Is there anything concerning your general health, your teeth, your anxiety levels, etc. you wish to discuss with you dentist in private?..... ☐ ☐

Please feel free to express any concerns or comments in the following section:_____

4. Who made your prosthesis? Dentist □, Denturologist □, Other □ : .....

	Y	N
5. Have you had to remake your prosthesis?.....	□	□
How many times have you had them remade? Upper:_____ Lower: _____		
6. Do you always wear your prosthesis?.....	□	□
Indicate when you do not wear it:		
7. Do you have any pain when opening your mouth?.....	□	□
8. Do you frequently have sores or pain in your mouth?.....	□	□
9. Do you remove your prosthesis when or if it causes you pain?.....	□	□
10. Are there certain foods you cannot eat with your prosthesis?..... Specify:		
11. Have dental implants ever been suggested to you?.....	□	□
12. Are you satisfied with your prosthesis?.....	□	□

I. ***Occlusal / Temporomandibular Joint Examination***

1. Are you *presently* experiencing any pain in you jaw joints or muscles?.....	□	□
2. Have you ever had pain in your jaw joints or muscles?.....	□	□
3. Do you feel this is a problem?.....	□	□
4. Have you ever been treated for problems of your jaw joint, or for facial muscle spasms?.....	□	□
5. Have you ever been treated for a "bad bite"?.....	□	□
6. Do you feel like your bite is closed?.....	□	□
7. Do you ever awaken with awareness of your teeth or jaw?.....	□	□
8. Do your teeth hurt from biting?.....	□	□
9. Do you have any pain or soreness or discomfort around your eyes, ears, or other parts of your face?.....	□	□
10. Do you frequently have ringing in your ears?...	□	□
11. Do you frequently have neck aches or stiff neck muscles?.....	□	□
12. Do your jaw muscles get tired frequently?.....	□	□
13. Do you have any difficulties opening your mouth widely?.....	□	□
14. Do you have any difficulties swallowing?.....	□	□
15. Does your jaw make noise when you move it?	□	□
16. Do you bite your nails, lips, pencils, etc.?.....	□	□
17. Do you clench or grind your teeth?.....	□	□
If so, indicate when you notice it happening the most: While asleep □, When stressed □, At work □ or school □, All the time □, Not sure □ , Other □:_____		

_____

	Y	N
c. Earaches……	□	□
d. Nasal disorders……..	□	□
e. Loss of voice or frequent or prolonged hoarseness…….....	□	□
f. Chest pain on the right □ or left □ side……	□	□
g. Palpitations……..…….……..	□	□
h. Breathlessness after mild exercise…….…….	□	□
i. Swollen ankles at night……	□	□
j. Jaundice…….……	□	□
k. Digestive problems…….....	□	□
l. Difficulty swallowing □ and/or dry mouth □……	□	□
m. Frequent sore throats…….....	□	□
n. Frequent cough……	□	□
o. Spit with blood……	□	□
p. Prolonged bleeding……..……....	□	□
q. Thirst…….....	□	□
r. Frequent urination……...	□	□
s. Kidney □ and/or bladder □ problems…….	□	□
t. Difficulty in tolerating heat…….……	□	□
u. Perspiration during the night……..……...	□	□
v. Weariness…….	□	□
w. Frequent headaches……..……	□	□
x. Migraines □ or tension □ headaches □ ……..….	□	□
y. Appetite problems…..…….……....	□	□
z. Insomnia……	□	□
3. Did you recently experience a significant weight loss or gain?……..……	□	□
4. Are you pregnant?……..……....	□	□
If so, how many months?_____		
5. Are you taking the birth control pill?.....	□	□
6. Are you currently experiencing menopausal symptoms?……..……	□	□
If so, how long:_____		
7. Do you have any allergies?……..……	□	□
If so, specify: Food □, Aspirin □, Penicillin □, Iodine□, Sulfonamides□Codeine □, Anesthesia □, Other □ Specify:_____		
_____		
8. Have you ever had an allergic reaction to any medications or metals?……..……	□	□
specify:_____		
9. Do you have artificial joints?.....	□	□

E. ***Family, Personal and Social History***

1. What is the physical and mental health status of your parents?

Mother: Good □, Average □, Bad □, Unknown □, Deceased □_____

Father: Good □, Average □, Bad □, Unknown □, Deceased □_____

2. On average, what is the physical and mental health status of your siblings (if applicable)?
Good □, Average □, Bad □, Unknown □, Deceased □

3. Have any members of your family suffered from any of the following problems?

	Y	N
a. Tuberculosis…….....	□	□
b. Diabetes □ or gestational diabetes □ ……	□	□
c. Hypertension……	□	□
d. Heart disease……	□	□
e. Cancer…….....	□	□
f. Epilepsy……..……	□	□
g. Psychological or Nervous disorders……	□	□
h. Asthma……..	□	□
i. Allergies……..….	□	□
j. Other……..….		
Specify:_____	□	□
4. Do you smoke or use tobacco?…….	□	□
If so, specify your method of use:_____		
_____		
5. Do you chew nicotine gum?.....	□	□
6. Do you drink alcoholic beverages? ……..	□	□
If so, how many per day/week?_____		
7. Are you overloaded at work and/or school?……	□	□
8. Do you have children?.....	□	□
9. In general, how do you evaluate your physical and mental health status? Good □, Average □, Bad □		

F. ***Dental History***

1. a) When was your last visit to the dentist?
0-6 months □, 6-12 months □, 1 year + □, Never □
Treatment received: _____
b) Please indicate your previous dentist's:
Surname:_____Name:_____
Tel. no._____

2. Have you previously any of the following dental treatments?

a. Oral hygiene □ and/or flossing □ instructions	□	□
b. Cleaning (prophylaxis)……	□	□
c. Bleaching…….....	□	□
d. Gum treatment □ or surgery □……	□	□
e. Orthodontic treatment……..……	□	□
f. Root canal treatment…….....	□	□
g. Dental fillings (restorations)..……	□	□
h. Crowns and/or bridges……	□	□
i. Partial and/or complete dentures……	□	□
j. Extractions……..	□	□
k. Dental implants……	□	□
l. X-rays……..	□	□
m. Surgery to remove a tumor of the lips/mouth	□	□
n. Other……..……....	□	□
Specify:_____		

3. On average, how often do you floss your teeth per week?
Everyday □, Every 2 days □, Once a week □, Rarely □,
Other □: _____

4. On average, how often do you brush your teeth per day?
Once a day □, Twice a day □, Three times a day □, Every 2 days □, Once a week □, Other □: _____

5. Do you use an electric □, a soft □, a medium □ or a hard □ toothbrush?

6. What kind of toothpaste do you use? Whitening □, For sensitive teeth □, With baking soda □, Total care □, All natural products □, None □, Other □:_____

7. Do you use whitening strips?.....	□	□
8. Do you chew whitening gum?.....	□	□
9. Do you only breath thru your mouth?.....	□	□
10. Do you have sensitivity?.....	□	□
Specify: Air □, Cold □, Hot □, Sugar □, Other □: _____	□	□
11. Do your gums bleed?.....	□	□
12. Are you missing any teeth?.....	□	□
13. Are you dissatisfied with the look of you teeth?	□	□

Explain:_____
_____

G. ***Dietary History***

1. Do you eat between meals?.....	□	□
2. Does your diet include any of the following?		
a. Chewing gum: *Sugar* □ *or Sugar free* □……..…	□	□
Intake per day: _____		
b. Breath mints: *Sugar* □ *or Sugar free* □……..	□	□
Intake per day: _____		
c. Candy bars and/or chocolate…...……..……..	□	□
Intake per day: _____		
d. Hard candies……..	□	□
Intake per day: _____		
e. Soft drinks…….	□	□
Intake per day: _____		
f. Cookies, cakes or other sweet bake goods…….	□	□
Intake per day: _____		
g. Fruit drinks……....	□	□
Intake per day: _____		
3. Do you drink coffee or tea?.....	□	□
Intake per day: _____		

How do you take it? Sugar □, Sweetener □, Dairy □,
Other □:_____

H. ***Prosthesis*** ***(Only for patients with dentures/partials)***

1. What kind of prosthesis do you wear?_____
2. Please indicate how long it's been since you had your extractions ? Upper:_____ Lower:_____
3. Please indicate the how long you have had your have had your prosthesis? Upper:_____ Lower:_____