

Last name:	First name:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Address:	City:	Postal code:
Home tel:	Cell phone :	Work tel:
Date of birth:	Medicare no:	Exp. date:
Referred by:	Reason for today's visit :	
E-mail :		

**Medical history**

	Yes	No	Reason, details and date
1. Are you being treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Have you ever had surgery or been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Do you have joint prostheses (hip, knee, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Have you gained or lost weight recently?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Are you taking natural or homeopathic products?	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____
8. Are you taking any medication <input type="checkbox"/> birth control <input type="checkbox"/> or hormones <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Please indicate all medication (including birth control, hormones) that you are taking or have taken in the last 6 months**

Medication and reason	Medication and reason

**Are you suffering or have you ever suffered from:**

	Yes	No		Yes	No
Blood disorders			Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
(hemophilia, anemia, prolonged bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart conditions			Nervous system disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Infarction (heart attack), angina, surgery, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Mental disorders or illnesses	<input type="checkbox"/>	<input type="checkbox"/>
Heart infection (endocarditis)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds or sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Surgery to replace or repair a valve/cusp	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or lung disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure high <input type="checkbox"/> low <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, fainting	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/ seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or manifestation with products containing :		
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Yes    No	Yes	No
Liver disorders (hepatitis A,B,C, cirrhosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Latex <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive system disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin <input type="checkbox"/> <input type="checkbox"/> Anesthetic <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify _____			Clindamycin <input type="checkbox"/> <input type="checkbox"/> Other : _____		
Stomach disorders ulcer <input type="checkbox"/> reflux <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other antibiotics <input type="checkbox"/> <input type="checkbox"/>		
Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other medical conditions that should be mentioned: _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other aspects</b>	Yes	No
Cancer (tumor) Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? ___ cig./day or ex-smoker <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you an AIDS virus carrier	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted or blood-borne infections (STBB)	<input type="checkbox"/>	<input type="checkbox"/>	Frequency : ___ drinks <input type="checkbox"/> /day <input type="checkbox"/> /week <input type="checkbox"/> /month		
Specify _____			Do you take recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	Do you take methadone?	<input type="checkbox"/>	<input type="checkbox"/>
Eye disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Earaches	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			
Prevention/treatments (e.g. : medication)	<input type="checkbox"/>	<input type="checkbox"/>			
Annual or monthly injection	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Section reserved for the dentist's special notes</b>	RMH
_____	_____
_____	_____
_____	_____

Signature of patient or designated representative \_\_\_\_\_

Date : \_\_\_\_/\_\_\_\_/\_\_\_\_  
          DD    MM    YY