MAXILLO 440
ORAL AND MAXILLOFACIAL SURGERY

CONFIDENTIAL MEDICO-DENTAL QUESTIONNAIRE

Dr Joel Abikhzer
Dr Éric Morin

Last name:	First name:	Sex: M ☐ F ☐	
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?	☐	☐	
2. Have you ever had surgery or been hospitalized?	☐	☐	
3. Do you have joint prostheses (hip, knee, etc.)?	☐	☐	
4 Have you gained or lost weight recently?	☐	☐	
5. Are you pregnant?	☐	☐	
6. Are you breastfeeding?	☐	☐	
7. Are you taking natural or homeopathic products?	☐	☐	Specify
8. Are you taking any medication ☐ birth control ☐ or hormones ☐?	☐	☐	

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
Blood disorders (hemophilia, anemia, prolonged bleeding)	☐	☐
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	☐	☐
Heart infection (endocarditis)	☐	☐
Surgery to replace or repair a valve/cusp	☐	☐
Blood pressure high ☐ low ☐	☐	☐
Dizziness, fainting	☐	☐
Frequent headaches	☐	☐
Jaw pain	☐	☐
Liver disorders (hepatitis A,B,C, cirrhosis, etc.)	☐	☐
Digestive system disorders or diseases	☐	☐
Specify _____		
Stomach disorders ulcer ☐ reflux ☐	☐	☐
Kidney disorders	☐	☐
Diabetes	☐	☐
Thyroid disorders	☐	☐
Cancer (tumor) Specify _____	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Are you an AIDS virus carrier	☐	☐
Sexually transmitted or blood-borne infections (STBB)	☐	☐
Specify _____		
Skin diseases	☐	☐
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention/treatments (e.g. : medication)	☐	☐
Annual or monthly injection	☐	☐

	Yes	No
Chronic pain	☐	☐
Epilepsy	☐	☐
Nervous system disorders or diseases	☐	☐
Mental disorders or illnesses	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis or lung disorders	☐	☐
Asthma	☐	☐
Hay fever/ seasonal allergies	☐	☐

Allergy or manifestation with products containing :

	Yes	No		Yes	No
Latex	☐	☐	Aspirin	☐	☐
Penicillin	☐	☐	Anesthetic	☐	☐
Clindamycin	☐	☐	Other : _____		
Other antibiotics	☐	☐	_____		
			_____		

Other medical conditions that should be mentioned: _____
_____

Other aspects	Yes	No
Do you snore?	☐	☐
Do you suffer from sleep apnea?	☐	☐
Do you smoke? ____ cig./day or ex-smoker ☐	☐	☐
Do you drink alcohol?	☐	☐
Frequency : _____ drinks ☐ /day ☐ /week ☐ /month		
Do you take recreational drugs?	☐	☐
Do you take methadone?	☐	☐

Section reserved for the dentist's special notes	RMH
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature of patient or designated representative

Date : _____/_____/_____
DD MM YY