CONFIDENTIAL HEALTH

Sex : Last name : ____________ First name : ____________

Address : ____________ City : ____________ Postal code : ______

Home phone : ____________ Work phone : ____________ Cellular : ____________

Birthdate : ____________ Email address : ____________

RAMQ number : ____________ Expiration date : ______ Social Insurance Number (optional) ____________

If you are under 18 years enter parent name ☐ Parent or Guardian :

In case of emergency contact : ____________

Reason for visit : ____________ Referred by : ____________

Are you on a welfare program? : Yes ◯ No ◯

	Yes	No
Are you presently under a physican's care ?........................	◯	◯
If yes, reason :		
____________		
____________		
____________		
____________		
Name of your doctor :		
Phone :		
Are you taking any medications or have you taken any during the last 6 months	◯	◯
if yes, which :		
____________		
____________		
____________		
____________		
3. Do you take homeopathic or natural products ?.......	◯	◯
Specify :		
- Do you take oral contraceptives ?....................	◯	◯
- hormones ? Specify :	◯	◯
4. Have you gained or lost a lot of weight recently?...	◯	◯
5. Are you pregnant ?..	◯	◯
Do you breastfeed?..	◯	◯
Have you suffered or do you suffer from :		
6. Cardiac problems	◯	◯
6.1 Infarct	◯	◯
6.2 Angina	◯	◯
6.3 Valvular problem	◯	◯
6.4 Heart murmur	◯	◯
6.5 Congenital cardiac disease.................................	◯	◯
6.6 Chest pains during effort	◯	◯
6.7 Coronary insufficiency..	◯	◯
7. Blood transfusion..	◯	◯
8. Rheumatic fever..	◯	◯
9. Blood problems :		
9.1 Hemophilia..	◯	◯
9.2 Prone to blood loss..	◯	◯
9.3 Anemia..	◯	◯
9.4 Abnormal bleeding or hemorrhaging during surgery	◯	◯
9.5 Other : Specify	◯	◯
10. Blood pressure : ◯ Low ◯ High	◯	◯
11. Frequent colds or sinusitis..	◯	◯
12. History of stroke..	◯	◯

	Yes	No
29. Ocular problems(eyes)..	◯	◯
30. Arthritis..	◯	◯
31. Osteoporosis..	◯	◯
32. Epilepsy..	◯	◯
33. Nervous disorders..	◯	◯
34. Psychiatric diseases..	◯	◯
35. Frequent headaches..	◯	◯
37. Dizziness, fainting..	◯	◯
38. Hearing problems..	◯	◯
38. Hay fever..	◯	◯
39. Asthma..	◯	◯
40. Do you smoke ?..	◯	◯
How many cigarettes? ______		
41 Have you ever had radiation therapy and / or chemotherapy (tumor)?..	◯	◯
42. Do you have AIDS ?..	◯	◯
43. Are you HIV positive ?..	◯	◯
44. Do you have artificial joints ?	◯	◯
45. Do you snore or have you been told that you snore?..	◯	◯
46. Have you ever had an allergic reaction to :		

	Yes	No		Yes	No
46.1 Latex	◯	◯	46.6. Penicillin	◯	◯
46.2 Food.	◯	◯	46.7 Codeine	◯	◯
46.3 Iodine	◯	◯	46.8 Other antibiotic	◯	◯
46.4 Aspirin	◯	◯	46.9 Local anesthesia	◯	◯
46.5 Sulfamides	◯	◯	46.10 Other	◯	◯

____
____
____

	Yes	No
47. Do you consume drugs ?..	◯	◯
48. Do you consume alcohol? ◯ Little or none ◯ Moderately ◯ A lot		
49. Have you ever been hospitalized or had surgery other than dental ?.........	◯	◯

If yes, which and when — DD/MM/YYYY

____________ date ______
____________ date ______
____________ date ______

50. Are you afraid of dental treatments ? ◯ A little ◯ A lot ◯ Not at all

	Yes	No
51. Is there anything concerning your health that you wish to discuss privately with your dentist ?	◯	◯
52. Dental insurance?..	◯	◯

	Yes	No
13. Pulmonary problems		
13.1 Chronic bronchitis	◯	◯
13.2 Pneumonia	◯	◯
13.3 Emphysema	◯	◯
13.4 Tuberculosis	◯	◯
14. Sinusitis	◯	◯
15.Jaundice	◯	◯
16. Hepatitis B	◯	◯
17. Hepatitis C	◯	◯
18. Digestive problems : Specify ______	◯	◯
19. Peptic ulcer	◯	◯
20. Liver disease (hepatitis A,B,C or cirrhosis)	◯	◯
21. Kidney disease	◯	◯
22. Do you have to urinate frequently	◯	◯
23. Sexually Transmitted Infections	◯	◯
24. Diabetes	◯	◯
25. Thyroid problems	◯	◯
26. Skin disease	◯	◯
27. Cerebrovascular accident	◯	◯
28. Do you take bisphosphonate	◯	◯

53. Insurance company ______
54. Subscriber name ______
55. Subscriber birthdate ______
56. Policy number ______
57. Identification number ______
58. How did you find out about our clinic.

- ◯ Yellow pages
- ◯ Internet
- ◯ Mail advertisement
- ◯ Media pages
- ◯ Clinic window
- ◯ I am a already a patient of the clinic
- ◯ Referred by current patient ______

Comments :

______
______
______

X. ______
DENTIST SIGNATURE

X. ______
PATIENT SIGNATURE

______
DATE