Consent to communicate with a health professional

Family physician, specialist, pharmacist, other

Name	Title	Institution / telephone

I hereby agree to allow the dentist and his or her staff to obtain information that is relevant to or consistent with the purpose of the file from the health professionals listed above or to disclose such information to these health professionals.

Signature of the patient or designated representative Date

Consent and identification

I have filled out this medical-dental questionnaire to the best of my knowledge.

Signature of the patient or designated representative Date

Patient him/herself ☐
Parent/guardian (if under 14 yrs. old) ☐
Legal/authorized representative ☐
Other ☐

Mr. ☐ Ms. ☐ _____
Name in print

I have reviewed the medical-dental questionnaire and indicated all changes.

Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD
Signature _____ Date YY/MM/DD

ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

Ordre des dentistes du Québec

CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

Personal Information

First name _____
Last name _____
Sex F ☐ M ☐
Date of birth _____ YY/MM/DD
Health Ins. No. _____ Expiry _____ YY/MM
Address _____
City _____
Province _____ Postal code _____

Contact Information

Home tel. _____
Work tel. _____
Cell phone _____
E-mail _____
For emergencies, call:
Name _____
Relationship to patient _____
Main tel. _____
Cell phone _____

Dental Information

Reason for today's visit _____
Do you fear dental treatments?
Not at all ☐ A little ☐ Very much ☐
Specify _____

Last visit 0-6 months ☐ 6-12 months ☐ + than 12 months ☐
Treatment(s) received _____

	Yes	No
With panoramic radiographs (large x-ray)	☐	☐
With intraoral radiographs (small x-rays)	☐	☐

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications.
It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

Patient _____

Operative precautions–For use by the professional

Medical history

	Yes	No	Reason, details and date
1. Would you like to speak privately with your dentist?	☐	☐	
2. Are you being treated by a physician?	☐	☐	
3. Have you ever had surgery or been hospitalized?	☐	☐	
4. Do you have joint prostheses (hip, knee, etc.)?	☐	☐	
5. Have you gained or lost a lot of weight recently?	☐	☐	
6. Are you pregnant?	☐	☐	
7. Are you breastfeeding?	☐	☐	
8. Are you taking natural or homeopathic products?	☐	☐	Specify _____
9. Are you taking medication?	☐	☐	
10. Are you taking birth control ☐ or hormones ☐ ?	☐	☐	

Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months

Medication and reason	Medication and reason

Please check Yes or No for each current or past condition

	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 (tumour) Specify _____	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Do you suffer from dry mouth?	☐	☐
Sexually transmitted or blood-borne infections (STBBI)	☐	☐
Specify _____		

	Yes	No
Skin diseases	☐	☐
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention / treatment (e.g.: tablets)	☐	☐
Annual or monthly injection	☐	☐
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:		
Latex	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Sulfonamides	☐	☐
Anesthetic	☐	☐
Food	☐	☐
Iodine-containing products	☐	☐
Other: _____	☐	☐

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 drugs?	☐	☐
Do you take methadone?	☐	☐

Section reserved for the dentist's special notes

_____

_____

_____

_____

_____

_____

_____

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