DENTAL FILE — 1

CONFIDENTIAL QUESTIONNAIRE

Telephone: work.: Area code | Ext.

Guardian | Status: Married: yes ☐ no ☐ Other ☐

Weight lb | Height ft. in. | Refered by:

Date of birth | Room no. | File no.

Surname and given name at birth

Commom name or spouse's name

Address

Postal code | Telephone (home) Area code | Sex M ☐ F ☐

Medicare no. | Attending physician

MAIN COMPLAINT

HEALTH HISTORY

Attending physician | Telephone: Area code

Indicate if:

	YES	NO
1. You are presently under a doctor's care	☐	☐
2. You are presently taking any drug or medication or have taken any in the last six months	☐	☐
If so, specify:		
3. You are pregnant	☐	☐
4. You are taking contraceptive pills	☐	☐
You are suffering or have suffered from:		
5. Heart disease	☐	☐
6. Rheumatic fever	☐	☐
7. Prolonged bleeding	☐	☐
8. Anemia	☐	☐
9. High blood pressure	☐	☐
10. Frequent colds or sinusitis	☐	☐
11. Lung problems (Tuberculosis)	☐	☐
12. Digestive problems	☐	☐
13. Liver disease (hepatitis A, B, or C, cirrhosis, etc.)	☐	☐
14. Kidney disease	☐	☐
15. Venereal disease (S.T.D.)	☐	☐
16. Diabetes	☐	☐
17. Thyroid problems	☐	☐
18. Skin disease	☐	☐
19. Eye problems	☐	☐
20. Arthritis - back problems	☐	☐
21. Epilepsy	☐	☐
22. Nervous disorders	☐	☐
23. Frequent headaches	☐	☐
24. Fainting spells	☐	☐
25. Earaches	☐	☐
26. Hay Fever - Asthma	☐	☐

HEALTH HISTORY (cont.)

Indicate if:

27. You have any of the following allergies:

	YES	NO		YES	NO
Foods	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Sulfonamides	☐	☐
Aspirin	☐	☐	Others	☐	☐

28. You have had a reaction to anesthesia	☐	☐
29. You have articular prostheses (hip, knee, etc.)	☐	☐
30. You have had radio therapy and/or chemotherapy treatments (tumor):	☐	☐
31. You are an AIDS virus carrier (HIV-infected)	☐	☐

If so, specify: with symptoms ☐ without symptoms ☐

DENTAL HISTORY

Last visit: 0-6m ☐ 6-12m ☐ + de 12m ☐

Treatments received (specify)

	YES	NO		YES	NO
1. Oral hygiene instruction	☐	☐	6. Crown(s) and/or bridge(s)	☐	☐
2. Gum treatment	☐	☐	7. Partial and/or complete dentures	☐	☐
3. Orthodontic treatment	☐	☐	8. Surgical treatment or extractions	☐	☐
4. Rootcanal treatment	☐	☐	9. Dental implants	☐	☐
5. Dental fillings	☐	☐	10. X-rays	☐	☐
			11. Other:	☐	☐

If so, specify:

Indicate if:

You were hospitalized or have undergone surgery other than dental

yes ☐ no ☐

If so, indicate which ones and when:

_____ 19____

_____ 19____

_____ 19____

Remarks:

I declare that I have answered the above questionnaire to the best of my knowledge.

Signature (patient or guardian)

Date a m. d

DENTAL FILE — 1

CONFIDENTIAL QUESTIONNAIRE

Telephone: work.: Area code | Ext.

Guardian | Status: Married: yes ☐ no ☐ Other ☐

Weight lb | Height ft. in. | Refered by:

Date of birth | Room no. | File no.

Surname and given name at birth

Common name or spouse's name

Address

Postal code | Telephone (home) Area code | Sex M ☐ F ☐

Medicare no. | Attending physician

MAIN COMPLAINT

HEALTH HISTORY

Attending physician | Telephone: Area code

Indicate if:

	YES	NO
1. You are presently under a doctor's care	☐	☐
2. You are presently taking any drug or medication or have taken any in the last six months	☐	☐
If so, specify:		
3. You are pregnant	☐	☐
4. You are taking contraceptive pills	☐	☐
You are suffering or have suffered from:		
5. Heart disease	☐	☐
6. Rheumatic fever	☐	☐
7. Prolonged bleeding	☐	☐
8. Anemia	☐	☐
9. High blood pressure	☐	☐
10. Frequent colds or sinusitis	☐	☐
11. Lung problems (Tuberculosis)	☐	☐
12. Digestive problems	☐	☐
13. Liver disease (hepatitis A, B, or C, cirrhosis, etc.)	☐	☐
14. Kidney disease	☐	☐
15. Venereal disease (S.T.D.)	☐	☐
16. Diabetes	☐	☐
17. Thyroid problems	☐	☐
18. Skin disease	☐	☐
19. Eye problems	☐	☐
20. Arthritis - back problems	☐	☐
21. Epilepsy	☐	☐
22. Nervous disorders	☐	☐
23. Frequent headaches	☐	☐
24. Fainting spells	☐	☐
25. Earaches	☐	☐
26. Hay Fever - Asthma	☐	☐

HEALTH HISTORY (cont.)

Indicate if:

27. You have any of the following allergies:

	YES	NO		YES	NO
Foods	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Sulfonamides	☐	☐
Aspirin	☐	☐	Others	☐	☐

28. You have had a reaction to anesthesia	☐	☐
29. You have articular prostheses (hip, knee, etc.)	☐	☐
30. You have had radio therapy and/or chemotherapy treatments (tumor):	☐	☐
31. You are an AIDS virus carrier (HIV-infected)	☐	☐

If so, specify: with symptoms ☐ without symptoms ☐

DENTAL HISTORY

Last visit: 0-6m ☐ 6-12m ☐ + de 12m ☐

Treatments received (specify)

	YES	NO		YES	NO
1. Oral hygiene instruction	☐	☐	6. Crown(s) and/or bridge(s)	☐	☐
2. Gum treatment	☐	☐	7. Partial and/or complete dentures	☐	☐
3. Orthodontic treatment	☐	☐	8. Surgical treatment or extractions	☐	☐
4. Rootcanal treatment	☐	☐	9. Dental implants	☐	☐
5. Dental fillings	☐	☐	10. X-rays	☐	☐
			11. Other:	☐	☐

If so, specify:

Indicate if:

You were hospitalized or have undergone surgery other than dental

yes ☐ no ☐

If so, indicate which ones and when:

_____ 19____

_____ 19____

_____ 19____

Remarks:

I declare that I have answered the above questionnaire to the best of my knowledge.

Signature (patient or guardian)

Date a m. d