Heritage Dental Clinic
In Medio Stat Virtus

(819) 682-1919
info@aylmerdent.com
www.aylmerdent.com

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M ☐ F ☐ Last Name: _____ First Name: _____
Address: No: _____ Street: _____ Apt: _____
City: _____ Postal Code: _____
Tel. Res.: _____ Work: _____ Cell: _____
Birthrate: Year: _____ Month: _____ Day: _____ E-mail: _____
Medicare No: _____ Expiry Date: _____ Social insurance No (optional) _____
If you are less then 18 years old, indicate name of parent ☐ or guardian ☐ _____
For an emergency contact: _____
Motive for visit: _____ Referred by: _____

MEDICAL HISTORY

Weight: _____ Height _____

1. Are you presently under doctor care? ..... Yes ☐ No ☐
   If so, reason: _____
   _____
   _____
   _____
   Last Name: _____ First Name: _____
   Tel: _____ (Ext.): _____
2. Are you presently taking any drugs or medication, or have you taken any in the last six months? ..... Yes ☐ No ☐
   If so, which: _____
   _____
   _____
   _____
3. Are you presently natural or homeopathic products? ..... Yes ☐ No ☐
   Specify: _____
   Birth control pills: .....
   Hormones: Specify: _____
4. Did you recently experience a significant weight loss or gain ..... Yes ☐ No ☐
5. Are you pregnant? ..... Yes ☐ No ☐
   Are you breast feeding ..... Yes ☐ No ☐

Are you suffering or have you ever suffered from:

6. Heart disease (stroke, angina, valvular problems, murmur) ..... Yes ☐ No ☐
7. Rheumatic fever ..... Yes ☐ No ☐
8. Blood problems
   - 8.1 Hemophilia ..... Yes ☐ No ☐
   - 8.2 Prolonged bleeding ..... Yes ☐ No ☐
   - 8.3 Clear Blood ..... Yes ☐ No ☐
   - 8.4 Anemia ..... Yes ☐ No ☐
   - 8.5 Other: Specify: ..... Yes ☐ No ☐
9. High ☐ Low ☐ Blood pressure ..... Yes ☐ No ☐
10. Frequent colds or sinusitis ..... Yes ☐ No ☐
11. Tuberculosis or lung problems ..... Yes ☐ No ☐
12. Digestive problems: Specify: _____ Yes ☐ No ☐
13. Stomach ulcer ..... Yes ☐ No ☐
14. Liver diseases (hepatitis A,B,C, cirrhosis, etc) ..... Yes ☐ No ☐
15. Kidney problems ..... Yes ☐ No ☐
16. Do you urinate often? ..... Yes ☐ No ☐
17. Venereal disease (V.D.) ..... Yes ☐ No ☐
18. Diabetes ..... Yes ☐ No ☐
19. Thyroid problems ..... Yes ☐ No ☐
20. Skin disease ..... Yes ☐ No ☐
21. Eye problems ..... Yes ☐ No ☐
22. Arthritis ..... Yes ☐ No ☐
23. Osteoporosis ..... Yes ☐ No ☐
    Do you take bisphosphonates? ..... Yes ☐ No ☐
24. Epilepsy ..... Yes ☐ No ☐
25. Nervous disorder ..... Yes ☐ No ☐
26. Mental illness ..... Yes ☐ No ☐
    Specify _____
27. Frequent headaches ..... Yes ☐ No ☐
28. Dizzy spells or fainting spells ..... Yes ☐ No ☐
29. Earaches ..... Yes ☐ No ☐
30. Hay fever ..... Yes ☐ No ☐
31. Asthma ..... Yes ☐ No ☐
32. Do you smoke? ..... Yes ☐ No ☐
33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor) Yes ☐ No ☐
34. Do you have AIDS symptoms? ..... Yes ☐ No ☐
35. Are you an AIDS virus carrier? ..... Yes ☐ No ☐
36. Do you have artificial joints (knee, hip, etc.)? ..... Yes ☐ No ☐
37. Do you snore or have you ever been told that you snore? ..... Yes ☐ No ☐
38. Do you have any of the following allergies?

38.1 Latex	Yes ☐	No ☐	38.6 Penicillin	Yes ☐	No ☐
38.2 Food	Yes ☐	No ☐	38.7 Codeine	Yes ☐	No ☐
38.3 Iodine	Yes ☐	No ☐	38.8 Other antibiotics	Yes ☐	No ☐
38.4 Aspirin	Yes ☐	No ☐	38.9 Local anesthesia	Yes ☐	No ☐
38.5 Sulfonamides	Yes ☐	No ☐	38.10 Others	Yes ☐	No ☐

Specify: _____
_____

39. Do you use drugs? ..... Yes ☐ No ☐
40. Do you drink alcohol? ..... No/A little ☐ In moderation ☐ A lot ☐
41. Were you ever hospitalized or have you undergone surgery ..... Yes ☐ No ☐
    If so, why and then:
    _____ Date _____
    _____ Date _____
    _____ Date _____
42. Do you fear dental treatments? No/A little ☐ In moderation ☐ A lot ☐
43. Is there anything concerning your health you wish to discuss privately with your dentist? Yes ☐ No ☐
    Remarks: _____
    _____

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FOR THE PHYSICIAN'S USE ONLY

Precautions:

DENTAL HISTORY

Last visit: 0-6 months ☐ 6-12 months ☐ 12 months + ☐

Treatments received: _____

1. Have you previously had dental treatments such as:	Yes ☐	No ☐	7. Partial or/and complete denture	Yes ☐	No ☐
2. Gum treatment	Yes ☐	No ☐	8. Surgical treatment or extraction	Yes ☐	No ☐
3. Orthodontic treatment	Yes ☐	No ☐	9. Dental implants	Yes ☐	No ☐
4. Root canal treatment	Yes ☐	No ☐	10. X-rays	Yes ☐	No ☐
5. Dental fillings	Yes ☐	No ☐	11. Others	Yes ☐	No ☐
6. Crown or/and bridge	Yes ☐	No ☐			

FOR THE PHYSICIAN'S USE ONLY

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures, as the case my be.

Signature: _____ Date: _____

Attending Dentist

TO BE COMPLETED BY PATIENT

I, the undersigned, hereby declare that I have read, understood and answered the above medical/dental questionnaire to the best of my knowledge. I also hereby promise to inform you any change To my health. I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my file will be kept in the office at all times and that only dentist(s) and his/her (their) auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

Signature: _____ Date: _____

Patient or Guardian

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